NOTE

This Microfiche meets the quality requirements of the American National Standard for Microfiche of Documents (ANSI PH5.9-1975). However, because of imperfections in the document from which it was made, it contains images that are illegible or difficult to read. The source document for this microfiche is the best copy that could be obtained prior to filming.

Congressional Information Service, Inc.
Washington, D.C.
CIS

DRUG ABUSE IN THE MILITARY—1981

HEARING

BEFORE THE

SELECT COMMITTEE ON
NARCOTICS ABUSE AND CONTROL
HOUSE OF REPRESENTATIVES

NINETY-SEVENTH CONGRESS

FIRST SESSION

SEPTEMBER 17, 1981

Printed for the use of the
Select Committee on Narcotics Abuse and Control

SCNAC–97–1–5

U.S. GOVERNMENT PRINTING OFFICE
85-333 O WASHINGTON : 1981

H961-1

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

LEO C. ZEFERETTI, New York, *Chairman*

PETER W. RODINO, Jr., New Jersey
CHARLES B. RANGEL, New York
FORTNEY H. (PETE) STARK, California
GLENN ENGLISH, Oklahoma
BILLY L. EVANS, Georgia
JAMES H. SCHEUER, New York
CARDISS COLLINS, Illinois
DANIEL K. AKAKA, Hawaii
FRANK J. GUARINI, New Jersey
ROBERT T. MATSUI, California
Ex Officio:
MARIO BIAGGI, New York
DANTE B. FASCELL, Florida
LINDY BOGGS, Louisiana
BARBARA A. MIKULSKI, Maryland
EARL HUTTO, Florida
GEORGE DANIELSON, California
WALTER E. FAUNTROY, District of Columbia

TOM RAILSBACK, Illinois
ROBIN L. BEARD, Tennessee
BENJAMIN A. GILMAN, New York
LAWRENCE COUGHLIN, Pennsylvania
ROBERT K. DORNAN, California
LAWRENCE J. DeNARDIS, Connecticut
E. CLAY SHAW, Jr., Florida
MICHAEL G. OXLEY, Ohio
Ex Officio:
MATTHEW J. RINALDO, New Jersey
ROBERT L. (BOB) LIVINGSTON, Louisiana
CHARLES F. DOUGHERTY, Pennsylvania
HENRY HYDE, Illinois

Committee Staff

Patrick L. Carpentier, *Chief Counsel*
Roscoe B. Starek III, *Minority Counsel*
Irving H. Soloway, Ph. D, *Professional Staff Member*
Elliott A. Brown, *Minority Professional Staff Member*

CONTENTS

Thursday, September 14, 1981

Page

Testimony of William Gordon Fink, Director, Office of Congressional and Public Affairs, Drug Enforcement Administration, accompanied by John Warner, Director, Foreign Operations 8

Prepared statement of William Gordon Fink 21

Testimony of John F. Beary III, M.D., Assistant Secretary of Defense (Health Affairs) 29

Prepared statement of John F. Beary III, M.D 33

Testimony of Brig. Gen. William C. Louisell, USA (retired), Deputy Assistant Secretary of Defense for Drug and Alcohol Abuse Prevention 34

Prepared statement of Brigadier General Louisell 39

Testimony of Maj. Gen. William R. Usher, USAF, Director, Personnel Plans, U.S. Air Force 162

Prepared statement of Major General Usher 164

Testimony of Maj. Gen. Mary E. Clarke, USA, Director, Human Resources Development, Office of the Deputy Chief of Staff for Personnel, Department of the Army 167

Prepared statement of Major General Clarke 168

Testimony of Rear Adm. Paul J. Mulloy, USN, Director, Human Resources Management Division, Office of the Chief of Naval Operations, U.S. Navy 171

Prepared statement of Rear Admiral Mulloy 172

Testimony of Brig. Gen. Anthony Lukeman, USMC, Director, Plans and Policy Division, Manpower Department, Headquarters, U.S. Marine Corps 175

Prepared statement of Brigadier General Lukeman 175

DRUG ABUSE IN THE MILITARY

THURSDAY, SEPTEMBER 17, 1981

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Washington, D.C.

The Select Committee met, pursuant to call, at 9:30 a.m., in room 2118 of the Rayburn House Office Building, Hon. Leo Zeferetti (chairman of the select committee) presiding.

Present: Representatives Leo C. Zeferetti, Henry Hyde, Benjamin A. Gilman, Glenn English, Joseph P. Addabbo, Earl Hutto, Frank J. Guarini, Tom Railsback, Robert K. Dornan, Lawrence J. De Nardis, Michael G. Oxley, and E. Clay Shaw, Jr.

Staff present: Patrick L. Carpentier, chief counsel; Roscoe B. Starek III, minority counsel; Irving H. Soloway, professional staff member; Ricardo R. Laremont, professional staff member; and James J. Heavey, press officer.

Mr. ZEFERETTI. Good morning ladies and gentlemen.

This morning, the House Select Committee on Narcotics Abuse and Control will explore the critical national security issue of drug abuse in the military. The Select Committee's Task Force on Drug Abuse in the Military under the leadership of Congressman Glenn English and accompanied by Congressman Benjamin Gilman conducted a survey of almost 2,000 enlisted members of the Armed Forces in Italy and West Germany. I want to extend my deep appreciation to Congressman English and Congressman Gilman for their commitment to this vital issue.

We also welcome the participation of Congressman Joseph Addabbo, Chairman of the Subcommittee on Defense of the Committee on Appropriations.

The Select Committee first undertook a survey of personal drug use among U.S. military personnel in November 1978. In that investigation it was found that drug abuse was a problem affecting significant portions of the U.S. Army stationed in West Germany and that the Department of the Army did not have sufficient resources committed to combating the problem. Following the investigation of 1978 and at the urging of the Select Committee, the Department of Defense and the various services developed several initiatives to remedy the situation.

The survey of 1981 had the primary purpose of assessing the impact made on substance abuse by the Defense Department's initiatives and programs. We visited the same military communities in West Germany in 1981 as we visited in 1978. In addition, the task force undertook a survey of U.S. Naval Forces and U.S. Marine units stationed in Naples, Italy, and serving aboard several ships in the Mediterranean Fleet. The survey also included a small number of Air Force personnel stationed at Ramstein Air Base in West Germany.

The results of the survey indicate that while some improvement, especially in the use of hard drugs such as heroin and cocaine by Army personnel has been made, the drug situation among the men and women of our armed services serving in Western Europe remains unacceptably severe.

Sixty percent of the lower enlisted personnel stationed aboard the U.S.S. *Forrestal* admitted using drugs while on duty in the month preceding the survey.

Sixteen percent of Army personnel and almost a quarter of Navy personnel surveyed admitted using marihuana/hashish each and every day, making these young people chronic users of a debilitating substance.

The overwhelming majority of service members surveyed rate the drug and alcohol treatment programs as "fair to poor." The full survey results reveal a shocking level of drug abuse within our Nation's military.

The Department of Defense has failed to develop effective treatment programs. Effective prevention programs for troops either do not exist or have not been used.

The Department of Defense, along with the services, needs to critically examine its programs. It must evaluate what is being used currently to combat the drug problem and to develop those programs which are working, discard the ones that have failed, and share among the services ways of attacking the substance abuse issue.

There are critical national security issues involved in the Select Committee's investigation of drugs in the military. A nation cannot hope to deter aggression, no matter how fancy the hardware, if the ranks are riddled with individuals who are chronic substance abusers.

There have been some signs of improvement in the military's attack on drugs, but these glimmers of light pale when compared to the high incidence of substance abuse existing within our Nation's military.

The Department of Defense and the military services are failing the American people by not insuring the combat readiness of the men and women who have volunteered to defend our country.

The Select Committee is anxious to develop the public record in today's hearing as to what steps can be taken by the Department of Defense and by the Congress in making real progress in turning back the tide of drug abuse. We have invited representatives of the Drug Enforcement Administration to provide us with an overview of the drug situation in Italy and West Germany. We are meeting today with representatives of the Department of Defense and of the services in a spirit of cooperation and a spirit of sharing commonly held beliefs that substance abuse among our Nation's military is unconscionable and that the problem deserves the highest priority that the Defense Department and the Congress can bring to bear upon it.

Thank you.

I would like to at this time ask my colleague Mr. English for his comments.

Mr. ENGLISH. Thank you, Mr. Chairman. I appreciate that.

In 1977, I was named chairman of the task force on drug abuse in the military. In one of the first briefings I received from Department of Defense I was told that the drug abuse problem in the military was a problem that was related to Vietnam and since we had left Vietnam and had gone to the all volunteer force that it was no longer a problem. In fact, I was told that roughly 10 percent of our military personnel might from time to time experiment with marihuana cigarettes and that, furthermore certainly far less than 1 percent would ever have anything to do with hard drugs. As we began our investigation in 1977 we soon discovered that that was not correct, that the enlisted man had a far different story. It was then that we first devised the questionnaire which was only intended to give us a ballpark figure, an indication as to what was really happening within the military services.

Our visit in 1978 to West Germany was one that I think was startling to many. Certainly, people within the military denied the validity of our study. I think since that time surveys undertaken by the Department of Defense itself, when given weight as far as including noncommissioned officers, bears out that our first study was indeed valid.

I feel without question that the results of this questionnaire are just as valid and perhaps even more so. I think it is important at this time that we recognize progress has been made due to the fact that the 1978 study dealt only with the Army in Germany. We do find that there is significant improvement in the areas of cocaine usage, heroin usage, barbiturates, PCP, and other miscellaneous drugs.

I think the Army should be commended for that. I think also we are going to be quite interested to find out why there has been a reduction in the use of these drugs. How can that success be applied to the other drug problems as they exist in the other services and what can be done to reduce the levels of marihuana and amphetamines use in the Army where there has been virtually no improvement since 1978.

I am hopeful that the Department of Defense will look on this as a positive study, one that will assist them in improving the record as far as drug abuse is concerned. I think it is important to note that the U.S. Congress and the American taxpayer has been asked to spend in the neighborhood of $1.5 trillion for the national defense of the country over the next 5 years. That is a lot of new hardware, very sophisticated hardware, hardware that becomes so much junk if it is not cared for properly, if it is not operated properly.

Certainly, the people that are going to be using that hardware are going to be maintaining that hardware have to be alert and have their faculties about them at all times.

So I think that today we can again take a look at what the drug abuse situation is and how we can help the Department of Defense, our national defense, deal with this particular problem. It will not be easy. We all recognize that drug abuse is a problem of our society and certainly the Department of Defense, and military personnel, our Armed Forces are a part of that society.

We would not want it any other way. Any problems that exist among the young people of this Nation certainly are going to be reflected within the U.S. military. But the main point is that given the state of our national defense, given the world that we live in, we simply cannot afford the type of drug abuse problem in the military that presently exists.

Thank you, Mr. Chairman.

Mr. **Zeferetti**. Thank you.

Mr. Gilman.

Mr. **Gilman**. Thank you, Mr. Chairman.

Mr. Chairman, I want to commend you for supporting this effort to once again review the extensiveness of narcotics abuse and trafficking in our military zones and among our military personnel. I want to commend the task force chairman, the gentleman from Oklahoma, Mr. English, who led our mission initially into Germany back in 1978 and who once again led our study mission to Italy and West Germany in June and July to investigate drug abuse in the military. His dedication in addressing this critical problem is vital to the overall mandate of our select committee and to the security of our Nation.

The results of this survey which we released yesterday are certainly startling. When we first traveled to Germany in 1978 and discovered the high levels of substance abuse among our troops stationed in that theater, we were assured by the Defense Department officials who joined us and took a hard look at all of the facts that we revealed that substance abuse would be a matter of deep concern and that high priority would be given to this issue.

Our survey which was undertaken within the past few months reveals that while the military has made some progress in attempting to turn back the tide of substance abuse—and that progress has been minimal—the problem remains and continues to be critical in the Army, the Navy, the Marine Corps.

Our investigation revealed some shocking findings: 60 percent of the lower enlisted personnel surveyed on an aircraft carrier, USS *Forrestal,* admitted to using drugs or alcohol while on duty; 42 percent of the Army personnel surveyed admitted using drugs on duty. Almost one-quarter of the Navy personnel surveyed admitted using marihuana or hashish each and every day.

The survey is a lengthy document. It will take several hours to study all the tables and statistics, but one fact clearly stands out from these cold numbers. The young men and women who volunteered to defend our Nation are not being given the adequate attention that they deserve and need to help combat this problem.

The substandard living conditions in most of the barracks overseas, the boredom, the cultural shock of living in a foreign land without adequate preparation, the loneliness, the long tours of duty in strange lands and lack of adequate recreational facilities, onboard ships like the *Forrestal* that are overcrowded, are all component factors that lead to substance abuse.

Quality of life is a critical factor in appreciating the reasons why many people choose to abuse drugs. Drug abuse is not a problem that can be solved by mere directives to unit commanders or pretending that it is a management exercise or an administrative difficulty.

Drug abuse is a profoundly human problem. It must be addressed as such if the top brass and the policy planners ever hope to accomplish something meaningful. The Defense Department has yet to declare war on drug abuse. All they have done is maintain a holding action. I came away from the study mission with the feeling that our Nation is faced with a real and present danger to its security. The bottom line is that we are failing in our effort to control substance abuse among military personnel, and particularly among personnel who are supposed to be combat ready.

Drug abuse must be addressed as a top priority issue in our defense establishment. It has not been addressed as such. The men and women who defend our freedom deserve the most creative and vigorous programs that can be made available. The trillions of dollars that will be invested in sophisticated military hardware will be no more than fancy mechanisms if the people operating and maintaining them are under the influence of narcotic substances. There is going to have to be basic changes made in the lackluster effort that has been brought to bear on this problem to date. The coming decade will be a dangerous time for nations throughout the free world.

I hope that we are going to see some improved effort as a result of this survey and as a result of these hearings. I think we are all concerned about the problem, and I hope that we can work together to improve the methods that have been utilized in the past.

Thank you, Mr. Chairman.

Mr. ZEFERETTI. Thank you, Mr. Gilman.

Mr. Addabbo.

Mr. ADDABBO. Thank you, Mr. Chairman.

I want to take this opportunity to commend you, Mr. English, Mr. Gilman, and other members of your committee for spotlighting this most important problem that besets our national security. Many of our sophisticated weapons systems the readiness of which as you pointed out are in jeopardy are handled by men and women under the influence of drugs.

I think that the only way this problem was spotlighted was the fact that men from your committee, our colleagues, went out to the field because in the hearings all you get is, "We are doing something." Sitting on Defense Appropriations we hear every year how much they need for drug abuse but the problem never goes away.

But they are always doing something. We find they are always doing what they did last year. If we match their testimony to the testimony of the previous year it is always the same, year for year.

What we are doing and what we are accomplishing are different things. We see when we get into the field and talk to the men, we find a different story. We were all dismayed last June 18 when I chaired a hearing in my subcommittee relative to the crash of a Marine EA-6B aircraft on the deck of the *Nimitz*. After we had the autopsy performed on 14 of those men—marines and sailors that were killed—it showed almost half of them had signs of drug abuse and some of them had taken drugs shortly before death had occurred.

We are still investigating all of that matter. Hopefully within the next week or so we will get the full report from the Navy. What that hearing did not point out was that on the *Nimitz* in the 6 months prior to the crash there were 124 formal cases of court martial or nonjudicial punishments against the *Nimitz* crew solely for drug abuse.

We have a continuing team of professional investigators in the field studying this very important question of the impact of drug and alcohol abuse. That report hopefully will be finished in November. We have a few interesting items so far from them. One of the points they brought out was the U.S. European Command estimates that the equivalent of about four U.S. combat infantry battalions assigned to Europe are lost because of drug abuse.

This indicates a high price in terms of both dollars and readiness paid for drug abuse. They also found a high number of drug infractions and arrests at sensitive military locations and included among the offenders were a number of military police on physical security assignments.

They found drugs are being sent to ships at sea and in some instances to the U.S. mainland in first-class letters and packages.

Although the military personnel are forbidden by U.S. Postal Service regulation to flouroscope, use drug dogs, or even open first class mail, two ship captains, realizing their responsibility, implied that mail would be tested. Suddenly 50 percent of that mail was returned to sender.

Finally, according to the Navy safety center medical officer reports from accident investigations, it appears that air crew alcohol and hangover effects were involved in 15 to 20 percent of the Navy's major aircraft accidents in calendar year 1979.

We were all shocked again recently by the crash of the A-7 onboard the *Kitty Hawk* and the loss of a helicopter at sea. I have asked the Secretary of the Navy for a full report including the medical report on urine analysis.

During the hearing last June we had General Louisell before us and other witnesses. They were aware of the problem and they at that time blamed to a great extent, society; that we live in a permissive society and that was carrying over into the forces. As we pointed out, the military cannot be a permissive society. It is a different society.

I would be interested to hear what the gentleman and others have to say especially, Mr. Chairman—I say this to the military and we will be following it through—our investigators were aboard the *Nimitz* and spoke to the men aboard the *Nimitz*. One officer aboard the *Nimitz* said, "We don't care what those smart aleck Congressmen do, we will do what we want. We are cutting in half our drug investigations, our tests."

That better not be the attitude. I am bringing the matter directly to the attention of Secretary Lehman because this Congress is not going away. The problem is not going away. Unless the military does something about it then the Congress will. That attitude better not be the continuing attitude within the military. This is a problem which involves the lives not only of the men aboard those ships or in the field but the lives of every American.

Congress is not doing this for the sake of television or anyone else. We are doing it as a protection, that these billions of dollars that we spend should not be simply defense spending but should be buying us real national security. These men and women are the key. Drug abuse detracts from that key.

So, we are deadly serious. The men who are dying are deadly serious about this. So carry that back to your junior officers. This is not going away and anyone who thinks it is going away will find out differently.

Thank you, Mr. Chairman.

Mr. **Zeferetti.** Thank you, Mr. Chairman of the Appropriations Defense Subcommittee. I want to join in the remarks you made and also indicate that we are very much concerned with the attitudes and the processes that follow the identification of drug use in the military. I think it is essential that once it is identified as being, being prevalent and a detriment to whatever duty functions that are there, I think whomever does the discovering should not be the one disciplined but encouraged to go forward with weeding out, if you would, those that are using the drugs and those that could be responsible for some kind of disaster occurring.

By that what I am directing my comment to is some of the testimony that was given to our people indicates that if a junior officer makes that kind of discovery sometimes he is given some form of a reprimand for having that particular type of problem within his unit. Ladies and gentlemen, I think that leads to sweeping things under the rug and hiding behind the facts and not doing what I think is right and just and what is in the best interest not only of the armed services but of our country overall.

Before we continue further, Mr. Hyde, do you have a statement?

Mr. **Hyde.** Thank you, Mr. Chairman.

I do not think this is merely a social problem. I think it is a criminal problem, and the statistics show it. It does little good to invest millions and billions on B-1 bombers and MX missiles if the military force that is to utilize these sophisticated and costly weapons is not fit physically or mentally to operate them.

I don't think money is enough. We think, as Mr. Addabbo has well said, by appropriating more money that we are going to solve these problems. Attitudes have got to change. We just can't blame the military. Our society tolerates drugs at rock concerts. We don't get shocked or excited about it any more. It is just tolerated and accepted.

Drugs are glamorized throughout our society. Television programs that cater to our young people make fun of drugs. Drugs are not portrayed as abhorrent or loathsome or deadly. They are a source of humor. As long as society is going to tolerate this among its young people, it is not surprising that the young people in the military are a reflection of that cultural attitude.

There has to be changes in attitudes, in our schools, and in our entertainment, if we expect to see the young people in the military far from home and bored to death not subject to the same problems.

I would suggest this. The problem is not confined to enlisted men. I have overheard high officers speaking who said one of the problems is that the lieutenants administering the programs have the same problem. I think we should look at that. I think enough has been said from us. I think we should hear the witnesses but I do congratulate Mr. Zeferetti, the Chairman of this very important committee, Mr. English and Mr. Gilman for doing extraordinarily important work, and Mr. Addabbo for his zeal. I think we can help focus public attention on this problem and make a halting step toward changing some of the attitudes that exist in our society today.

Thank you, Mr. Chairman.

Mr. ZEFERETTI. Mr. Guarini.

Mr. GUARINI. Thank you, Mr. Chairman. I want to thank you for the leadership that you have given and the members of this committee for their participation in putting the spotlight on this debilitating social problem. It is regrettable it also involves the military. I await the testimony of the military people together with the governmental leaders. Their recommendations and suggestions will be most important to us. I want to make a footnote and say we spend billions of dollars on military defense. We have taken this money away from many of our social need programs, programs where we asked people to make sacrifices across the board. People who are needy, handicapped, elderly, and indeed our working people.

The question of military preparedness is foremost in the minds of all of us. It is a pity we call on these people to make sacrifices in the field and our military may be crippled by this drug problem. It is important that we get to the bottom of it and do something about it now.

Mr. ZEFERETTI. Thank you.

Our first witness this morning is Mr. William Gordon Fink, Director of the Office of Congressional and Public Affairs of DEA, the Drug Enforcement Administration. I believe Mr. Fink will be accompanied by John Warner, Director of Foreign Operations of DEA.

Good morning.

TESTIMONY OF WILLIAM GORDON FINK, DIRECTOR, OFFICE OF CONGRESSIONAL AND PUBLIC AFFAIRS, DRUG ENFORCEMENT ADMINISTRATION, ACCOMPANIED BY JOHN WARNER, DIRECTOR, FOREIGN OPERATIONS

Mr. FINK. Good morning. It is a pleasure to be here to provide your committee with the overview of drug availability in Europe with emphasis on Italy and Germany.

Mr. ZEFERETTI. We have your statement. Without objection it will be included in the record in its entirety.

Mr. FINK. I would like to summarize the statement briefly so we can move on to questions that you have. Based on a request from committee staff I would like to highlight changes in trends that we have seen in Europe in the last couple of years. And there have been significant changes—one in Germany with respect to heroin.

Heroin is the number one priority for the Drug Enforcement Administration as well as many of our European counterparts. Our intelligence and the intelligence of our associates in Europe have indicated reduced availability of heroin in Germany and a corresponding reduction in the abuse statistics. We look at what the Germans have experienced in 1980 and since 1979, there is a 54-percent reduction. Heroin is still available in Germany. But what has happened is only those mainline traffickers with good connections are able to be assured of their supply of heroin. Many of the small traffickers, the independent entrepreneurs have been hit and affected by a number of actions so there is still heroin available but it has been significantly reduced over the last year or year and a half.

The reason for this reduced availability is the result of several factors. The Turkish Government has taken aggressive action against the traffickers within their country—those traffickers being the main source of supply for the abuse in Germany. The Yugoslav Government has been very aggressive at its borders in checking trucks that transit from Turkey en route to Germany and has made several large seizures.

The Germans have taken two very important actions. First, they now require visas for Turks who enter their country. Second, they have stepped up their law enforcement activity. I believe that a combination of these factors in addition to what DEA has done with our special agent's office is responsible for this progress. Some of the credit belongs to John Warner, who before his promotion headed that region, because DEA helped our European counterparts put a program together to combat a drug that is thoroughly international in its trafficking and origin.

I think the results in Germany help demonstrate what can be done and accomplished when you have that type of international cooperation.

Italy is a different story. Drug abuse and availability of heroin continues to rise in Italy. It is still the major source for heroin that enters the United States because Italy is not only an abusing country, it is also a source area. There are several clandestine laboratories in addition to the sophisticated trafficking organizations, typically entitled "organized crime," that are part of heroin importation into this country.

Italy has taken aggressive action against those traffickers and against those operators. We have had a large number of clandestine labs seized, eliminated in some cases major stockpiles of the raw material or finished product available at those laboratory sites.

We feel these actions on the part of the Italians, assisted by the intelligence we provided, has helped check the rate of increase of heroin availability in this country. So, in both countries we still have heroin availability and in Italy it is still continuing to rise.

We see that trend continuing in the future with respect to Italy and there will be two factors that will affect heroin availability in Europe in the coming years.

First, is the action taken by the Government of Pakistan because Pakistan is now more of a source country than it has been before for heroin hydrochloride. It has been one of the three countries that has produced opium that ends up in the heroin conversion laboratories. But now Pakistan has emerged as a source of heroin which has affected the United States and it affects our partners in Europe because it is turning out to be more of a source for these countries. The other factor is the bumper crop of opium in Southeast Asia. Before the influx of Southwest Asian heroin from Afghanistan, Pakistan, and Iran into Europe, Southeast Asia was the major source with respect to heroin.

With the bumper crop that has been harvested in Southeast Asia we expect to see a return of some of that heroin to Europe, price changes in the structure and those factors will be monitored closely by DEA and our counterparts to determine what effect that will have not only on abuse in Europe, but also what effect it could have on the drugs being imported into this country.

I would like to address the rest of the drug picture in Europe. As far as dangerous drugs are concerned, Europe is still a major source of supply for the precursors that are required to produce many of the abused drugs, particularly methaqualone. They are also in the consuming area.

There are methamphetamine and amphetamine laboratories located in Europe. There is intelligence which indicates that LSD laboratories are located in Europe, so they have some of the same problems that we do in this country. The source of supply is in their own area in addition to that which is imported into those countries.

With respect to cocaine—there has been a significant rise in cocaine availability in Europe. This was particularly noted in 1980. There was some aggressive action by some of our law enforcement counterparts in Europe that had at least a temporizing effect as a result of major seizures and arrests of major traffickers in Europe and South America, where cocaine originates. We will be monitoring to see if that trend continues, but cocaine is still available and can be obtained in Europe if you do have the proper connections.

The drug that is probably the most available in the cannabis family in Europe is hashish. We had a recent change in the source of supply for hashish. That supply presently feeds into Europe and to a lesser extent the East Coast of the United States. Lebanon has taken over as the major producing country, a title originally that we gave to Pakistan and Afghanistan. But we believe that the occupation by the Soviets in Afghanistan has had an impact on the production in that country and their ability to export hashish from Afghanistan; so, Lebanon with the good weather they have had and a lack of internal law enforcement has emerged as the principle source of hashish.

Large seizures of hashish have been made in Europe. The principle means of trafficking is via the importation by trucks, some coming through the Eastern European countries; by ships; as well as by automobiles in the classic mode of trafficking and methods of concealment.

Hashish is a more potent drug than the marihuana that is abused in this country. The THC content of the hashish in Europe will range between 5 and 15 percent, while the marihuana THC content in this country ranges from 1 percent up to a high of 7 or 8 percent for the Hawaiian and Californian. So hashish is a more potent form of cannabis.

If you are dealing with hashish oil, which is a concentrated form, the THC content can go over 50 percent. There is some hashish oil traffic within Europe and it is potentially available for abuse in European countries.

Let me conclude by describing our relationship with the military forces. Military forces have their own investigative arms. They differ in each service, and I am sure the gentleman that will follow me will describe their investigative elements. We team up with those investigative elements when they request assistance on major investigations and often the investigations that are going across the international borders. So when they ask for help we are able to provide them assistance, but generally they are responsible for policing their own.

There is a constant exchange of intelligence two ways with the military investigative services and, in some cases, their intelligence arms. I think we have a major assistance role that we perform in training. Last year we trained over 1,000 military investigative personnel both abroad and in this country. We set up special schools to train their investigative personnel. We supply instructors for a 1 week course in their school for basic investigators. When any of the investigative services of the military have asked for training help we have provided assistance. We try to make sure we meet their needs.

We have found that the people we are training are competent and we continue to provide the assistance—particularly in the training areas—that they need. That concludes my summarization, Mr. Chairman and I would like to remain available for questions along with Mr. Warner both on my comments as well as my written statement.

Mr. ZEFERETTI. Thank you very, very much, Mr. Fink.

First, let me ask you, what is the street price, the street market picture in terms of availability to our service people? Are drugs very readily available for them? Is it a market that has a variation of hashish, marihuana, anything you want to get your hands on? Especially if you are talking in West Germany where our task force was.

Mr. FINK. It does vary by country. It particularly affects the overall availability of drugs in this country. The reduction of heroin in Europe and Germany, as I mentioned, is probably associated with some decline of abuse by the military because of its reduced availability in general. We also are aware that when some major traffickers are involved they will go outside of the country including the military for their source of supply.

Mr. ZEFERETTI. I am not relating to traffickers. What I am talking about is the availability in the immediate area. Is there anything going on that your agency does with the military? I know you indicate they have their own investigative body.

Mr. FINK. Correct.

Mr. ZEFERETTI. But if the availability is that great, is there anything done immediately as a response to that to offset it? I know sometimes you can't deal with the Government and local authorities but is anything done within our own armed services and our agencies?

Mr. FINK. The gentlemen that will procede us will be able to respond to the specifics, but we are very much aware of the fact that there are close relationships between the military investigators and military police and the foreign counterparts that do police the areas in which they are located. So, when there is abuse indicated, availability indicated in the area, they work with the local authorities—not with DEA because it is a local problem in

Germany—to see what can be done. John, do you want to add anything to that as far as specifics on availability?

Mr. **Warner**. Mr. Chairman, the military conducts joint investigations with their German counterparts in the vicinity of military installations in an attempt to reduce the supply of all kinds of drugs to the forces stationed in the area. There are a number of programs. DEA is not participating because of the limited resources that we have in Europe. However, the fallout, the organizers and sources of the drugs when they are identified by these task forces and are brought to our attention—we pursue it on an international level.

Mr. **Zeferetti**. If you had to speculate as to how those large amounts get aboard a ship like an aircraft carrier, what would your guess be as to—because you are talking about a large quantity of drugs if you are talking about a ship that is going to be out to sea for 60 days, and you have a complement of 60 percent that are using it, you are going to need a lot of stuff to supply all of these people. If you had to guess how the majority of that infiltrated that vessel, what would your guess be as someone that has been in this business for a long time?

Mr. **Fink**. I mentioned how drugs move in bulk across the international borders. If you are dealing with hashish, it is a smaller bulk and hashish oil would be much smaller. As far as having to transport it by any type of physical security, anyone that is going to be watching what you bring on board—with respect to your specific question—on the carrier—that would principally occur in Italy. Maybe John can add to that.

Mr. **Warner**. I believe there are two major sources for naval vessels at sea. One, the calls that are made to various ports especially in the Mediterranean in the Middle East. The second source is the U.S. mail. The U.S. Postal Service which provides the mail as well as the content of some of the packages that are really contraband. In the first instance, the calls that are made to various ports, we cooperate with the Naval Investigative Service—and they will address this themselves—in working with the local police forces at the ports to enable naval investigators to work undercover prior to the arrival of the ship to identify the small-scale traffickers and then allow the local police forces to apprehend them. In addition, the Navy, of course, has a dog program and that is being utilized in checking personnel coming from those port cities. As far as the postal situation is concerned, this is I believe a continuing problem.

Mr. **Zeferetti**. There is an indication that they are using uppers. Is that also available wherever you go? Are the pills that readily available?

Mr. **Warner**. Yes, sir, in many countries especially in the Middle East there are no prescription requirements and these drugs can be obtained in any drugstore and of course they are also peddled by small-scale traffickers.

Mr. **Fink**. And availability is going up, not as dramatically as heroin did when Europe experienced the problem of 2 or 3 years ago, but it is more gradual like cocaine availability in Europe.

Mr. **Zeferetti**. Mr. Gilman.

Mr. **Gilman**. Thank you, Mr. Chairman.

I want to welcome the DEA representatives with us today and thank them for their efforts in the past in the European theater and elsewhere. You mentioned the good cooperation with the military in policing of narcotics; have you had occasion to meet from time to time with the military enforcement people to discuss the availability of narcotics in the NATO theater and in the 6th Fleet area?

Mr. WARNER. Yes, sir, we have several instruments through which this liaison takes place. In the Federal Republic of Germany there is a committee structure which includes the military, the German Federal Criminal Police, and the State Criminal Police Organization, as well as DEA.

The exchange of information and policy determination concerning joint operations is accomplished in those meetings. In addition, we have participated with the special assistant for drug enforcement matters to the European Command at briefings in Italy at NATO headquarters and elsewhere.

I think these mechanisms have been extremely helpful in providing our knowledge concerning the international traffic to the military and vice versa to obtain local information concerning the abuse in and around military installations.

Mr. FINK. That also happens in Washington, where we deal with headquarters equivalents, particularly when they have had conferences the military would bring their people together from worldwide posts. We are active participants in many ways, from presenting identification techniques to the overall picture of what trends we see so they can be prepared both on the treatment and enforcement side.

Mr. GILMAN. As far as you know, has any plan been evolved for attacking the availability and accessibility of narcotics in and around our military bases and naval ports in Western Europe or in the Mediterranean area?

Mr. FINK. I think General Louisell and his people can respond to that.

Mr. GILMAN. I am asking if you have any firsthand knowledge. Have you been involved in any planning of that nature?

Mr. WARNER. Yes, sir, especially in the Federal Republic of Germany. We are not, we do not have a similar structure in Italy.

However, in the Federal Republic of Germany we do have a joint policy determination body for narcotics, the Permanent Working Group of the Federal structure.

Mr. GILMAN. Who participates in that working group?

Mr. WARNER. The working group consists of and is chaired by the assistant director in charge of drug enforcement of the Federal Criminal Police in Wiesbaden. Participating are all the heads of the narcotic units of the various BKA's, the State Police Criminal Police organization. The military is represented No. 1 by SADEM, the Special Assistant for Drug Enforcement Matters to the European Command. OSI and the Navy is not represented to the best of my knowledge.

Mr. GILMAN. Is DEA represented?

Mr. WARNER. Yes, sir.

Mr. GILMAN. How often does the task force meet?

Mr. WARNER. They meet, I believe, on a bimonthly basis.

Mr. **Gilman**. Do they engage in long-range planning to try to reduce the traffic in and around the military bases?

Mr. **Warner**. Yes, sir. This is only part of their responsibility. Obviously since it is a Federal German committee with the U.S. participation it has a broad range of responsibilities to reduce the availability of drugs in the Federal Republic including the military. There is also a military subcommittee that meets regularly and there are several other subcommittees, one looking into the aspect of military justice, and their German counterparts and other subcommittees deal with treatment and rehabilitation.

Mr. **Gilman**. Have you taken part in any of the work of the working group?

Mr. **Warner**. No, sir. I have only participated in the law enforcement working group, as I was not really stationed in Germany. I was stationed in Paris as the Regional Director, but our Special Agent in Charge in Bonn participates in as many of these working groups as he can.

Mr. **Gilman**. You say there is a long-range plan that has been adopted to try to reduce the flow of narcotics in and around our military bases from this working group.

Mr. **Warner**. Yes, sir.

The working group is constantly working on policy concerning the reduction of drugs.

Mr. **Gilman**. And there is actually a plan of operation, a long-range plan of operation, that is in place?

Mr. **Warner**. I am not sure whether there is a formal plan.

Mr. **Gilman**. Who in your agency would be responsible for overseeing that responsibility?

Mr. **Warner**. It would be our country attaché in Bonn. If there is such a plan we certainly will make it available to you.

Mr. **Gilman**. Well, wouldn't you be knowledgeable about such a plan in your post?

Mr. **Warner**. In terms of a specific plan directed to the military I really don't know and I would assume that our military colleagues would have the specific knowledge about that.

Mr. **Gilman**. As far as you know, Mr. Warner and Mr. Fink, you don't know of any plan. Is that what you are telling us?

Mr. **Fink**. In a formal sense, no. Again, let me remind you this is a German body that is meeting, of which the United States is a participant.

Mr. **Gilman**. You tell me it is a working group with cooperation between the German forces, our military personnel, and the DEA, yet you don't know of any working plan to reduce narcotics in and around our bases.

Mr. **Warner**. Not in terms of a formal plan, I am not aware of a formal plan that has a specific objective and means to achieving the objective and so on.

Mr. **Gilman**. Do you think we need such an objective to reduce the flow of narcotics into and around our military bases?

Mr. **Fink**. I think our law enforcement counterparts both in Germany and Italy are trying to do that and are committed within the extent of their resources, which have been increased in both countries, by the way, against the narcotics traffickers, are making progress and as I mentioned in Germany——

Mr. Gilman. I have no doubt and I am not questioning the fact that your agents are out there trying to do their job. I am asking if there is some concerted effort to develop long-range planning to try to reduce all of the trafficking and accessibility and availability of drugs in and around our military posts?

It seems to me DEA would be an important part of that planning. If DEA doesn't know about that kind of planning, I wonder if that kind of planning has been put in place?

Apparently you are not aware of any.

Mr. Warner. I am not aware of a formalized plan.

Mr. Gilman. Mr. Warner, you are in charge of the European operations for DEA are you not?

Mr. Warner. Yes, sir.

Mr. Gilman. Thank you.

Mr. Zeferetti. Mr. English.

Mr. English. Thank you very much, Mr. Chairman.

Mr. Fink, early this summer when we were preparing to make this investigative trip, we were briefed by the DEA as to drug availability, particularly in West Germany.

At that time we expressed an interest in particular about heroin, given the high availability and usage that we found there in 1978.

You told us at that time or I should say, DEA did, that heroin availability in Germany was roughly two to three times what it was in 1978 and that was one of the reasons, I might say the primary reason, that I made the request of the chairman for another survey.

Now you come before us in this hearing and tell us that it is far less than what it was in 1978.

I suppose I am a bit troubled and perplexed as to why DEA was not aware of the levels of availability this spring—why they would be so far off the mark. I might also say that the perception of DEA now with regard to the availability of heroin in Germany coincides with what junior enlisted personnel are telling us.

Mr. Fink. Sir, I am not sure exactly when in the spring you were briefed. But we do collect statistics and our European counterparts are not as sophisticated as we have grown to be in this country on collecting data with respect to deaths and injuries.

But, I do know and our intelligence reports that were made available to the committee—I am not sure specifically as a part of your briefing or not—have indicated a decline in purity of the seizures in Europe, increased seizure activity.

The abuse statistics as far as deaths probably won't come in until late in the spring or summer to show, for example, the 1980 figure on the number of deaths in Germany as being reduced from the number of deaths in 1979.

Mr. English. That is kind of after the fact.

Mr. Fink. Yes, sir.

Mr. English. What we are talking about here, is that we have quite a number of people overseas. We met some of them, who are there for the specific purpose to keep watch over their regions to determine what is taking place as far as drug activity. And as I said, we were told this spring, in fact, it was early summer, within a matter of days before we left during a final briefing that heroin availability was two to three times what it had been in 1978.

The thing that troubles me is I don't understand why the intelligence would be lagging that far behind what was actually happening on the ground.

Mr. FINK. I don't think it was that far behind and I will work with your staff to find out who provided the specifics. But there certainly hasn't been that startling a change just in a few months.

This is a trend that we have been monitoring over the last year. But I will again hasten to point out that in many areas we are dependent on the intelligence provided by our counterparts.

Mr. ENGLISH. What about the U.S. military in those areas?

Mr. FINK. The military is a part of that. I must also——

Mr. ENGLISH. Let me just fill you in a little bit on just what the heck is going on over there, Mr. Fink. The situation is this: In 1978, with the junior enlisted personnel we surveyed in Germany, we ended up with a roughly 51 percent saying that heroin was easy to obtain on their posts, no problem.

We come down to 1981, a couple of weeks after we received our intelligence briefing by the DEA, and we had 19.1 percent who said it was easy to obtain. Obviously, there had been a rather dramatic change between 1978 and 1981 as to the availability of heroin. I don't understand.

As you point out, you know, obviously one of two things happened, this happened within a 2-week period of time.

Mr. FINK. No, sir.

Mr. ENGLISH. Or it happened over a period of a couple of years. And I don't understand why DEA didn't know about it.

Mr. FINK. I wouldn't say over a period of a couple of years. I think 1978 represented a peak and, if you are familiar with the statistics and you have seen our charts, it showed a very, very rapid increase in not only heroin availability but the deaths in Germany and their extreme concern.

They had a death rate that was higher than we have ever experienced in the United States, when normalized to per million of population.

Mr. ENGLISH. The point is, let me interrupt you right there. This is one of the points I am trying to make. What we are interested in at this particular time, what we were trying to obtain was DEA's assessment as to what is out there and available.

Now overdose drug deaths point out what is being used, not necessarily what is available, but what is being used. It may be an indicator. But what we were requesting was information on what is available, what is coming into that area, how much is there out there?

We didn't even ask specifics, all we asked was general information; how does this compare to 1978? We were told it was two to three times more than it was in 1978. What troubles me, is: How good is the DEA intelligence?

Let me go on, I am not just bringing this up just to give you a hard time. The reason for this is that I think it is critical that the Department of Defense in dealing with the drug problem be able to identify and identify accurately what drugs are being used, what drugs are available and to what extent they are available.

If you have a large amount of heroin that comes into a commander's area he ought to know about it, so he can take steps to deal with it. It doesn't make as much sense, for instance, in Germany where you have a 19-percent factor to put the same level of emphasis, than say, at Fort Sill, Okla., because you just don't have that kind of availability of heroin at Fort Sill, Okla., to my knowledge, that you do in Germany. It is an entirely different situation.

Those are the types of tools that military commanders must have.

Mr. **Fink**. Absolutely.

Mr. **English**. If DEA can't provide it, I don't know where they, the commanders, get it. Evidently the best thing we can do is go out and ask the junior enlisted personnel what is out on the streets.

Mr. **Fink**. No, sir. We work closely with our counterparts.

Let me give you an example of how we are not only trying to strengthen our intelligence exchange, but also trying to help the Germans, the BKA in Wiesbaden: We have assigned an intelligence analyst full time posted in Wiesbaden to help improve, one, their data collection and; two, the interchange. Of course, that would be added to what we get from the military.

Mr. **English**. Given the information that we received, I am not sure who should be helping who, because obviously the information we were provided wasn't any good.

Mr. **Fink**. Mr. English, I must say it has been consistent with what your staff has been receiving in the "weeklies" in our articles. It may have been one specific briefer was off, which I will have to apologize for if that was true.

Mr. **English**. We had several briefings.

Mr. **Fink**. It is certainly something that has been reported in our periodicals.

Mr. **English**. Let me say this: It wasn't staff either, it was me. I sat in on that briefing. I sat in on two or three in which we went over this very issue. This is a point I always made, I was vitally interested.

Mr. **Fink**. Was it Germany as a whole?

Mr. **English**. Germany as a whole. Let me point out something else. You mentioned Italy, the large growth you had in Italy.

[A letter and memo of clarification from DEA appears on p. 25.]

Mr. **Fink**. Of heroin availability.

Mr. **English**. I assume what you are talking about is that heroin going into the United States, right?

Mr. **Fink**. No, sir, their abuse is going up, their deaths are increasing at a large rate and this is of major concern to their government.

Mr. **English**. What is available to U.S. servicemen?

Mr. **Fink**. The picture has changed in Italy as far as the source of drugs. Italy used to abuse mostly Southeast Asian heroin. The labs producing Southwest Asian heroin are operated by organized crime families. There was an initial reluctance to let that heroin leak, so to speak, into their own economy such that they would be subject to more law enforcement pressure by the Italian authorities.

That picture has changed as reported to us by the Italian officials in that there is more Southwest Asian heroin available. Syrians are a part of this increased availability. There is a Syrian population in Italy importing heroin from Syria.

You now have a choice of heroins available both to Italians and of course, as a result because it is available in the country, and to the military stationed there or those who have port calls.

Mr. ENGLISH. Let's have another one of these ballpark figures. How would you compare the availability of heroin to the American soldier in Germany as opposed to the American marine and sailor in Naples, what is the availability of heroin comparison in those two areas?

Mr. FINK. The answer is reduced availability in Germany, I am not sure about Naples. You may have to ask the military representatives for the specific on Naples. Again, we don't monitor the specific availability in foreign countries.

Mr. ENGLISH. That is exactly my point. How in the world are these military commanders going to be able to make an assessment as to what is available in their areas of hard drug usage?

Mr. FINK. By their own people working in the intelligence area and the criminal investigators who work in those cities, who know.

We do not work in cities in Europe. Our job is to handle the international traffic and institution build. So we don't go out and buy drugs on the street in Europe or run a street sampling program.

Mr. ENGLISH. What you are telling me is there is no cooperation or interchange between the U.S. military intelligence and DEA.

Mr. FINK. I did not say that.

Mr. ENGLISH. Then why don't you know?

Mr. FINK. We exchange intelligence on the international level of what is available. What foreign enforcement personnel tell us we feed back to the military; we also feed it back to the foreign enforcement organizations. But when the military—and John Warner gave you an excellent example—when there are port calls to be made, we work very closely. We introduce these new agents, the new naval investigative agents to their foreign counterparts that we do know and work with.

So they can start working around the cities before a port call is made. They can find out who the traffickers are. The local foreign enforcement authorities are the ones to take the local enforcement action; DEA is not involved with that.

Mr. ENGLISH. We met with your people in Italy, we got our briefing from DEA in Italy. During that briefing that representative told us he had been in the Naples area, he even wanted to go down to the Naples area and conduct seminars with U.S. dependents in that area.

It seems to me that he was quite interested in being involved in what was taking place on the drug scene within Naples.

Now, somewhere there is a breakdown of information getting either from him to you or from you all to the U.S. military or vice versa, but the point I am trying to make is that this is very critical and it does lead to a misperception, because what perception you are giving here today is that the heroin situation for the U.S. military is much worse in Italy than it is in Germany and that is not correct.

Mr. **Fink**. I didn't say that, sir. I said the heroin availability for that country is reported in their reports both in health and law enforcement. The Italians will be the first to admit they are experiencing major influx of heroin and abuse. And their death rate is starting to take off like the Germans did 2 or 3 years ao.

Mr. **English**. For your information, in Germany, the E-1 through E-4 availability factor, it is easy to obtain, we ended up with 19 percent. In the Naples area with the Marines and Navy we ended up with 6 or 7 percent.

I think, quite frankly, I have to be honest with you, I have more faith in those figures than I have the briefing I received.

Mr. **Fink**. I can't dispute those figures, sir, because they represent localized statistics, collected for a specific purpose, and I really can't make any comment on it. We do get equivalent surveys that a foreign government might run in a particular city. We feed that intelligence to the military.

Mr. **English**. You give it back to the military?

Mr. **Fink**. Yes; there is a two-way exchange with the military.

Mr. **English**. Doesn't the military tell you?

Mr. **Fink**. Yes, sir, they do.

Mr. **English**. What have they told you about the Naples area that is available?

Mr. **Fink**. I would have to refer to the man in charge.

Mr. **Warner**. Mr. English, we have five DEA agents in Italy. Over the last year and a half, approximately six or seven laboratories, heroin laboratories, have been seized through the efforts of these agents working with their Italian counterparts.

This is the thrust of our efforts in Italy, not to collect intelligence on the availability of heroin in Italian cities.

Mr. **English**. Mr. Fink just got through telling me they receive, on a regular basis, reports from Defense Intelligence people, Naval Investigative Service or whoever, as to what is taking place in areas in which they have people stationed.

Mr. **Warner**. Yes.

Mr. **English**. I don't understand if they get those reports, what do they do, do they just file the whole thing, or is that passed on to other people?

It seems to me you ought to have a good idea, if you have large concentrations of American citizens, not to mention American defense frontline personnel, we are depending on those people to defend this country. It seems to me the DEA would have some interest at least in what is going on in those areas.

Mr. **Fink**. We do. And I am sure when that agent makes his trip to Naples and a military adviser gives him information he does document it; it comes into the system that feeds not only Washington, but also it will go to the European offices, this committee, and Germany if it is relevant. It will be included in our publications if there is a significant change.

Mr. **English**. Thank you.

Mr. **Zeferetti**. Thank you. There is a vote on the floor. We will go down to vote and be back in about 10 minutes.

[Brief recess.]

Mr. **Zeferetti**. Mr. Fink, Mr. Warner, would you please take the witness chair once more. We apologize for the delay. There was a series of votes that occurred on the floor. But we should be in pretty good shape for the next hour anyway.

Mr. Railsback?

Mr. Railsback. Thank you, Mr. Chairman.

I want to welcome John Warner, whom I haven't had a chance to see for a long time. It is good to see you again.

How would you characterize the trafficking network in West Germany? Are the principal traffickers still the guest workers?

Mr. Warner. Yes, they are still heavily—the majority of the couriers and organizers are still Middle Eastern guest workers and the traffic moves out of predominantly Istanbul into Western Europe and into the Federal Republic.

There has been a decrease in the number of seizures that have been made at ports and borders on the transit route over the last, well, certainly the last few months, which is reflective of the visa requirement that has been instituted in Germany.

However, some of these Middle Eastern traffickers have settled in adjacent countries in and around the Federal Republic, such as Switzerland and Austria.

Mr. Railsback. Is it your view that the American installations have been targeted or singled out for activities of these traffickers? Or do you feel it's the West German population, itself, which I know has had an increasing problem? Are Americans separately targeted because we have the American service facilities and bases?

Mr. Warner. My answer would be no, we are not specifically targeted. It is a traffic, a commercial traffic for profit and whoever has the money to purchase the drugs they are more than happy to furnish them. It has nothing to do with U.S. military presence there.

Mr. Railsback. So our soldiers are really receiving their supplies from the same sources that the West German population would be receiving them?

Mr. Warner. Yes, sir.

Mr. Railsback. What kind of a network is there for the Southeast Asian heroin as contrasted with the Southwest Asian heroin?

Mr. Warner. Southeast Asian heroin has made a slow comeback. The opium harvest in the Golden Triangle, which is estimated to be about 600 tons this year, is slowly finding its way into Southeast Asia, through the addict population and there have been increasing instances of Europeans predominantly going to Southeast Asia and bringing heroin back.

There have been some instances of organized crime figures who were previously obtaining their heroin from the Italo-American connection, now going to Southeast Asia to obtain their supplies.

Mr. Railsback. I am just curious about Amsterdam, for instance. At one point Amsterdam was the real focal point for Southeast Asian heroin.

Mr. Fink. The Dutch moved very aggressively and arrested and deported many of those traffickers. And I think they are on guard now to help check any reemergence.

But I refer back to a comment I made earlier. We are going to be watching very closely the pricing and the trafficking groups, because Southeast Asian heroin is just reemerging in the international markets in quantity. We will be watching in Europe not just for Europeans' sake but because that could be a transshipment point into the United States. Our west coast offices are running street buy programs now to see if there is any reemergence in areas where, for instance, there was Mexican heroin, Los Angeles for example, and San Francisco, where we did see Southeast Asian heroin.

Mr. RAILSBACK. I hate to even ask this question because when I visited Heidelberg, I became very sympathetic to the plight of our American service people. I think many of them are underpaid and in some cases do not have adequate recreational facilities.

But I think I ought to ask because not too many years ago we were being warned that the United States itself can expect a tremendous influx of the Southwest Asian heroin which has happened to an extent but not maybe to the extent that we thought it might occur.

Is there any indication that any of our service people are acting as traffickers of drugs into our country?

Mr. WARNER. No, sir; there has been no recent indication of a reestablishing of service criminal organizations furnishing drugs to the United States.

Mr. RAILSBACK. Is it your view that Interpol is playing an increasingly important role in our enforcement efforts? Have they really become more involved now?

Mr. WARNER. Yes, sir. Since we have placed a DEA high level official with the Secretariat, General Secretariat in San Cley, in charge of their drugs subdivision, the work of Interpol has improved tremendously.

However, you have to realize that Interpol is not an investigative agency, it is an after-the-fact recordkeeping and coordinating agency. They have been extremely helpful in some of the international investigations where several countries have had bits and pieces of information on one trafficking group to bring them together and where all of the agencies concerned are participating in the exchange of information.

This has been extremely helpful.

Mr. RAILSBACK. Yes. Thank you very much.

Mr. ZEFERETTI. Thank you, gentlemen, thank you so very much for sharing your testimony with us this morning.

[The prepared statement of Mr. Fink follows:]

PREPARED STATEMENT OF WILLIAM GORDON FINK, DIRECTOR, OFFICE OF CONGRESSIONAL AND PUBLIC AFFAIRS, DRUG ENFORCEMENT ADMINISTRATION, U.S. DEPARTMENT OF JUSTICE

Good morning. I appreciate this opportunity to appear before the House Select Committee on Narcotics Abuse and Control to lay the foundation for today's hearing regarding drug abuse within the U.S. Armed Forces in Italy and West Germany. It is my intent this morning to provide an overview of the drug trafficking situation in Europe, specifically in Italy and West Germany, so that the focus of today's hearing can be viewed from a general perspective.

Heroin continues to be a primary concern—it is the drug that poses the gravest threat to many cultures worldwide. The abuse of this substance is of paramount importance in Europe, as it is the United States. Consequently, I will direct the majority of my remarks to the heroin supply and availability situation. Additionally, where other dangerous drugs play important roles in the overall drug scenario, I will endeavor to highlight those situations for you.

In order to understand the present situation and to aid in forecasting the future, I think it important to spend a moment recapping the historical development and dynamics of the heroin production and trafficking that has had an impact in Europe and the United States. In the middle to late 1970's, Southeast Asia was the predominant heroin source for most European addicts. By the late 1970's, Southwest Asian heroin (originally known as Middle Eastern heroin) had become prevalent in Germany, and began appearing at the street level in isolated incidents in other parts of Europe, as well.

In 1979, and most particularly in the second half of that year, when the amount of Southeast Asian heroin reaching Europe declined sharply. This was due, in part, to a series of enforcement successes both in Europe and in Southeast Asia, as well as to a drought which adversely affected opium cultivation in the Golden Triangle region. At the same time, Middle Eastern nationals achieved dominance in manufacturing and trafficking of Southwest Asian heroin. They benefited from an increase in raw opium from the poppy fields of Pakistan, Afghanistan and Iran. This led to increased production of Southwest Asian heroin and allowed the Middle Eastern traffickers to fill the vacuum created in Europe by the declining availability of Southeast Asian heroin.

Farmers throughout Southwest Asia continue to produce opium despite a variety of impediments. Preliminary reporting indicates that 1981 opium production in this region will remain at levels approximately the same as in 1980, i.e., about 800 metric tons. This remains, however, substantially less than the bumper crop of 1,200 to 1,600 metric tons produced in 1979.

Specifically, opium production in Pakistan is estimated to have dropped from about 700 metric tons in 1979 to a maximum of 125 metric tons in 1980. A final estimate based on on-site surveys places the 1981 crop between 85 and 125 metric tons. The opium stockpiled from the 1979 harvest led to low prices for the 1980 crop, which probably accounts for the reduced planting of opium poppies. However, if as a result, the opium price should increase this year, and prices for legitimate agricultural crops remain comparatively low, farmers may be enticed to increase their illicit plantings in the fall.

Reliable information has not been developed on this year's opium yield in Afghanistan. However, it is known that fighting between the Soviet forces and the Afghan insurgents has been heavy in Afghanistan's opium producing eastern provinces and this, in turn, has had an adverse effect upon opium cultivation. It is probable that the 1980/81 harvest will be below the estimated average pre-war yield of 300 metric tons for this area.

The internal turmoil accompanying the Islamic Revolution in Iran has weakened narcotics enforcement efforts in that country. Although the Iranian government has taken a hard public line on narcotics, it has not been able to dissuade rebellious Kurdish farmers from cultivating opium, which is an important cash crop for these people. Lack of civilian government control reportedly has resulted in increased illicit opium poppy cultivation. Opium production in 1980 probably equaled the 1979 estimate of approximately 600 metric tons. Most of the opium is consumed domestically by Iran's estimated 500,000–1,000,000 opium addicts and approximately 50,000 heroin addicts. According to some reports, Iran imported as much as 400 metric tons of Pakistani and Afghan opium to meet this domestic demand. Much of this opium is converted into morphine base and heroin in small clandestine laboratories located in the Kurdish territory along the Iran-Turkey border.

Thus, although much of the region's opium production is consumed intraregionally by the area's large opium and opiate addict populations, a significant portion remains available for conversion into heroin for international smuggling to markets in Europe and the United States where traffickers may obtain hard currencies for their drugs.

Reports from a variety of sources over the past year have suggested a shift away from Iran to Pakistan as the leading regional opiate source country for international markets. Among the factors influencing this change are: international travel restrictions on Iranian nationals during 1980; the highly-publicized executions of some narcotics offenders by the Government of Iran during the latter part of 1980; the Iran-Iraq War; the continuing travel restrictions into or out of Afghanistan; and, by contrast, the relative ease of movement into and out of Pakistan.

Pakistani and other traffickers have taken advantage of several opportunities to avail themselves of the tremendous financial windfalls which can be realized from narcotics trafficking to the West. Among these have been: the wide variety of transportation modes linking Pakistan to both the east and west; the relative absence of travel restrictions into and out of Pakistan; the large Pakistani expatriate communities in the transit areas of the Persian Gulf and market areas of Western Europe; and a number of business and financial systems which have been exploited to facilitate international monetary transactions between Pakistani and foreign traffickers. As a further indication of the success of this commerce, DEA has noticed a significant improvement in the purity and strength of Pakistani-produced heroin.

The process through which opium is converted into heroin and then transported to European addicts appears to be undergoing change. A review of seizure statistics, price and purity figures and other indicators suggest that ther amount of Southwest Asian heroin entering Europe has stabilized following a year of decreasing availability.

One of the more promising disruptions in the movement of opiates from Southwest Asia to Europe has occurred in Turkey. Recent enforcement efforts by the Turkish government have resulted in the capture of many traffickers known or thought to be responsible for handling the major portion of heroin reaching Europe from that country. Consequently, the amount of heroin being transported to Europe has proportionately diminished and the number of Turkish couriers has been reduced.

Certain forecasts regarding the future heroin situation in the region can be made based on our knowledge of patterns and trends and available data.

TURKEY

While heroin processed in Turkey was significant in Europe in the mid-1970's, serious enforcement efforts undertaken by Turkish and West European governments to control this traffic have led to a sizeable drop in the availability of Turkish-processed opiates on today's markets. Despite this drop, Turkish couriers are still responsible for the majority of heroin smuggled from the Middle East to Europe, although there are growing indications that other ethnic groups, principally Pakistanis, Iranians, and even Indians, are making serious inroads to the European markets.

IRAN

Because of the rapidly changing political situation in Iran, it is difficult to predict with any degree of accuracy the heroin availability threat from this country. Opiate consumption in Iran has always exceeded the incountry production capabilities although, in relative terms, such production can be expected to remain high. Our best intelligence suggests to us that the economic collapse in Iran has caused many people to seek more secure means of insuring their financial future once the political problems of Iran have been settled. To generate hard currencies, some people have chosen to produce and smuggle high-grade heroin to the West. Seizures of Iranian heroin have occurred throughout Europe and the United States. Travel restrictions of Iranians to the United States have reduced such traffic over the past year or so. Basically, we can expect that any relaxation of such travel restrictions is potentially conducive to an increase in availability of heroin from Iran.

SOUTHEAST ASIAN HEROIN

Despite serious droughts which adversely affected the 1979 and 1980 opium yields and therefore limited heroin production in Southeast Asia, addicts in France, Spain and South Italy have continued to be supplied by that heroin. With the recent Southeast Asian bumper opium yield, heroin production has begun to increase and as a result more of this drug can be expected in Europe. We believe that this will be seen especially in France, Spain and Italy and also in the Netherlands which has a large Asian community .and which was the headquarters for several Southeast Asian drug trafficking groups in the mid-1970's.

ITALY

Like many other Western Euopean countries; Italy had little if any major opiate abuse problems in the early 1970's However, with the spread of inexpensive, high-quality Southeast Asian heroin across Europe after 1974, there gradually emerged a national heroin abuse problem. This market was largely serviced by Italian nationals in a variety of trafficking roles.

In addition a rise in the number of overdose deaths, seizures of Southwest Asian morphine base, heroin, and clandestine conversion laboratories in Italy have risen dramatically since 1978. These seizures reflect Italy's growing domestic heroin market, as well as its increased importance as an international heroin source country.

At about the same time that Italy developed its heroin addict population, reports began to surface regarding the re-establishment of European heroin production. First reports were sketchy, but early seizures of morphine base, heroin, and clandestine laboratory equipment added credibility to the rumors and speculation that some of the old "French Connection" era hands were active again.

Seizures and investigative leads in both Italy and the U.S. as early as 1977 pointed conclusively to the establishment of a viable, competent heroin production capability. A number of closely integrated, highly-sophisticated trafficking groups were believed responsible for importing the necessary raw materials (morphine base) into Italy from suppliers in the eastern Mediterranean, such as the Turkey, Lebanon and possibly also Syria. This precursor material is converted into high-quality injectable heroin in clandestine laboratories located principally on the island of Sicily and along the Milan-Marseilles corridor.

As in the days of the French Connection, investigators determined that this production capability was directed toward supplying the lucrative U.S. heroin addict market, to the exclusion of the domestic Italian market. Generally, the domestic market was left to feed off intermediate sources of supply in Northern Europe, who, in turn, obtained their supplies from Asia—both East and South.

By the time of the remarkable Southwest Asian opium bumper crop of 1978-1979, Italy was in the grip of an increasingly widespread heroin epidemic. Heroin addiction continues to constitute the most serious national drug abuse problem in Italy. According to the best available estimates, Italian and U.S. government authorities believe there may be as many as 100,000 heroin users in the general population. Most of these are believed to be between the ages of 18 and 24.

The spread of the heroin abuse problem in Italy is documented by statistics showing Italy second only to the Federal Republic of Germany in the number of overdose deaths per million persons in Europe. Between 1977 and 1979, overdose deaths in Italy rose from 40 to 126. At the end of 1980, 203 overdose deaths had been recorded; while reliable data are not yet available for 1981, unofficial information indicates a continuing serious overdose problem.

A choice of heroins has been readily available to Italian addicts over the past two and a half years. There is a large community of Syrians in Italy and Syrian traffickers regularly fly in from Damascus with heroin. Lebanese traffickers commonly transport heroin to Italy from Beirut.

Turks bring it in overland. Italian dealers and addicts fly to Bangkok and return with Southeast Asian heroin. The heroin reaching Italy from Syria and Lebanon can be expected to continue in about the same quantities. The presence of Turkish smuggled heroin may increase as Turkish traffickers, who can no longer enter Germany or the Benelux countries without visas, try to expand their market. Southeast Asian heroin will become increasingly available in Italy, since a demand for that heroin already exists and supplies are expected to grow.

Heroin is not the only troublesome drug abuse problem. Other problem areas confronting Italian authorities include the increasing abuse of cocaine from South America, as well as widespread abuse of hashish from Africa and the Near East. There is also continuing abuse of dangerous drugs, principally amphetamines, barbiturates and hallucinogens, like LSD.

WEST GERMANY

The Federal Republic of Germany has played several roles in the trafficking of Southwest Asian opiates. During the early 1970's, West Germany was exploited as a secondary transit and storage point for morphine base destined for the heroin laboratories in Southern France. In more recent years, West Germany has become a major consumer of Southwest Asian heroin.

Prior to 1977, the heroin market was supplied by ethnic Chinese traffickers who used Amsterdam as the hub for distributing Southeast Asian Heroin to Western Europe. In early 1977, this control was challenged by Middle Eastern traffickers smuggling high-grade injectable heroin from opium grown and processed in illicit laboratories in Southwest Asia and eastern Turkey.

Heroin from Turkey has dominated the German market since the middle 1970's. However, significant Turkish enforcement efforts, as well as increased German interdiction interest, as demonstrated by the guest-worker visa requirement law, have led to a diminished supply of heroin reaching Germany from Turkey. This change, however, will make Germany a tempting target for Pakistani and Southeast Asian heroin traffickers.

There is no evidence that illicit heroin laboratories have ever been established inside West Germany. This country remains principally a victim/consumer country. Ninety-five percent of all the Southwest Asian heroin seized in West Germany in 1980 was intended for consumption within the country. West Germany has not developed, at this point, into a major staging area for heroin destined for the United States.

Estimates of the heroin addict population in Germany have ranged from 45,000 to 100,000 depending on the data source used for compilation. The greatest percentage of these addicts are German nationals.

Drug overdose deaths rose consistently in the 1970's and peaked in 1979 at 623, the majority of which were attributed to heroin abuse. In 1980, 494 drug overdose deaths were reported, a significant decrease from the 1979 total. According to the Bundeskriminalamt (BKA-German Federal Police) statistics, there were 65 overdose deaths reported for the first quarter of 1981 (1/81—3/81). For the same period last year, there were 117 overdose deaths. This represents a 44 percent reduction. Officials believe that the decrease in the number of overdose deaths is attributable, in great part, to a reduction in the street-level purity of heroin.

Over the past year, there has been a dramatic decrease in the amount of heroin seized in West Germany. This decrease is one indication that heroin is less readily available in Germany. Also, there have been decreases in heroin purity at the street level and a decline in overdose deaths, which again signals less availability.

Reduced availability does not mean that there is a scarcity of heroin in West Germany. The vast majority of the seizures in Germany are not "cold hits" at border points. Rather, they occur as a result of investigations. Enough heroin is thought to be reaching Germany to allow most traffickers to supply their regular customers, although at reduced purity levels. However, the traffickers have no surplus heroin and for that reason, as well as for fear of police enforcement measures, they are not seeking new untrusted customers. This has caused a decrease in seizures.

Besides heroin, several other types of drugs pose significant social, health, and enforcement problems in West Germany. Cocaine abuse, while not as widespread as in the U.S., is gaining in popularity. Cocaine is smuggled into Germany via commercial aircraft and vessel from South America. Both Germany and South American traffickers smuggle the cocaine directly into the FRG by these means, as well as via overland routes from sources in Spain, France, Italy, and the Netherlands.

Hashish remains available and widely abused throughout West Germany. The majority of the hashish smuggled into the FRG originates in Southwest Asia, primarily Lebanon and Pakistan, and is smuggled into the country via Transporte Internationale Routier (TIR) trucks. However, smuggling by ship and air cargo has also been utilized. Although sizable quantities of marihuana are sometimes smuggled in from sources in North Africa, marihuana is not a significant problem.

Dangerous drugs of various types are readily available in West Germany; the scope of abuse of dangerous drugs and psychotropic substances appears to be minor when compared with the rate of heroin abuse.

West Germany, in particular the Free Port of Hamburg, has been identified as a significant source and/or transit area for methaqualone and other psychotropic substances destined for Colombian traffickers. The principal reason that this situation developed was because Germany had not fully implemented the provisions of the 1971 Psychotropic Convention. However, recently, the government enacted a new law and imposed new regulations to correct this problem. Additional legislation is pending before the German Parliament which would increase penalties for serious drug offenses.

* * * * * * *

Gentlemen, I hope that this brief overview of drug availability in Italy and Germany will better enable the Committee to examine in-depth the issues relating to drug abuse by the U.S. Armed Forces. I would be delighted to respond to any questions that you may have.

U.S. Department of Justice,
Drug Enforcement Administration,
Washington, D.C.

Hon. Glenn English,
House of Representatives,
Washington, D.C.

Dear Mr. English: DEA appreciated the opportunity to appear before the Select Committee on the topic of Drug Abuse by the Military in Europe. Your personal concern as evidenced by the two fact-finding trips to Europe has helped illuminate an area of concern to the Congress and the American public. As our representatives stated in the hearing, we have and will continue to give priority to the requests we receive for assistance to our military counterparts. Our participation in the training of over 1000 military personnel each year is a statistic that illustrates our commitment.

I would like to seek your assistance in clarifying the hearing record with respect to heroin availability trends in West Germany. Our review of information provided to you and the Committee shows a consistent reporting—often highlighted—of the decrease in heroin availability in 1980 with the trend continuing in 1981. We specifically noted this trend in a DEA memorandum (April 22, 1981—enclosure) prepared for you prior to your recent trip to Europe. The DEA briefing book for the European trip also highlighted the continuation of this reduced heroin availability trend. I believe we have been consistent in our reporting and for reasons which you appreciate would hope the hearing record would reflect this consistency. If for any reason you feel that this was not the case, I will personally review the matter when provided the specifics.

Your can be assured of our continuing support to you and your staff. I hope you share our concern on the need to clarify the hearing record.

Sincerely,

Francis M. Mullen, Jr.,
Acting Administrator.

Enclosure:

April 22, 1981.

Hon. **Glenn English,**
Chairman, Government Information and Individual Rights Subcommittee,
House of Representatives, Washington, D.C.

Dear Chairman English: In response to your request of April 3, 1981, for information regarding the drug suppression efforts of DEA's overseas offices, with particular reference to our cooperation with the Department of Defense in Europe, the following is submitted.

OVERVIEW

DEA's European activities span the entire continent of Europe and extend to Southwest Asia. Twenty-two district and resident offices provide day-to-day presence and expertise to counterparts throughout the entire region. Of major interest to DEA is the developing drug trafficking patterns that emerge over a given time and which respond well to intelligence analysis. By providing timely and accurate analysis, our agents are often several steps in front of the traffic and are thus in a position to alert the indigenous services to greater vigilance. Coupled with DEA's domestic posts, our overseas operations afford us a global barometer of the world's drug availability which can be translated into risk factors for domestic planning purposes.

In addition to DEA's cooperative enforcement program overseas, we carry the responsibility of making on-site appraisals of host governments' capabilities in the drug law enforcement field. By conducting local in-country training schools, we provide greater awareness and technical skills to police and Customs officers, who generally may not be exposed to such specialized data in their national training academies. Furthemore, in concert with the Department of State, our agency provides stateside training for selected officers of important drug producing and drug trafficking areas of the world. Residual benefits of both programs are evident in the good will and high degree of cooperation and success our students share with us when their formal training concludes.

In addition to our training and enforcement operations, we collect and transmit great amounts of information and intelligence about changing drug trends and patterns throughout the world. To accomplish this, our agents obtain information from informants, general media sources, local counterparts and other American and foreign agencies having relevant responsibilities. In turn, our voluminous intelligence flow is analyzed by our Headquarters Office of Intelligence, as well as our Regional Intelligence Units in the field.

By careful research and critical examination of such raw data, we are often able to forecast developments and, thus, apply resources and personnel in the most desirable areas. For example, our routine investigations in 1976 and 1977, in Europe, began to uncover evidence that a new and virulent form of heroin was emerging from Southwest Asia. Over the next few years, we were able to alert our foreign colleagues as well as our own government to this new threat. After a sudden and tragic rise in heroin overdose deaths in Europe in 1979 and 1980, we are beginning to see a settling out and even a downward trend in some selected key areas.

In late 1979, in response to this perceived threat, DEA instituted a Special Action Office for Southwest Asian heroin (SAO/SWA). By application of financial resources as well as personnel and administrative support, we were able to monitor closely the expected heroin increase in this country and abroad while taking steps to attack the importers and distributors through vigorous and far reaching investigations. Our asset removal operations were intensified and international conspiracy investigations were pursued across borders through mutual assistance treaties and formal extraditions.

This period we witnessed a similar increase in the awareness and responsiveness of not only our foreign counterparts, but also of other American agencies, notably the Department of Defense and the Department of State.

While we have installations of American troops in many areas served by our overseas agents, the greatest single concentration remains in the Federal Republic of Germany (FRG). In the FRG, DEA maintains the greatest complement of agents in its European operations. Our ten special agents and one intelligence analyst enjoy exemplary relationships with their FRG colleagues. In addition, DEA maintains close and frequent liaison with American military officials whose primary responsibility is control of the drug traffic affecting the American forces.

Over the years, we have been successful in working together with them to resolve problems of mutual concern. To ensure the permanency of this arrangement, we have instituted both formal and informal processes to promote greater cooperation and collaboration among all the various agencies dealing with drug law enforcement.

SPECIAL PROGRAMS

To counter the threat of Southwest Asian heroin, the Drug Enforcement Administration has initiated nineteen special enforcement and intelligence programs in Europe and Southwest Asia during the last year. These programs have been in the following countries: Austria, Belgium, France (2), Greece, Germany (4), Italy (2), Lebanon, Netherlands, Pakistan (3), Spain and Turkey (2). These programs, specially funded by DEA's Special Action Office/Southwest Asian Heroin in the Office of Enforcement and by the Office of Intelligence, have augmented the manpower and financial resources available to the DEA offices in the respective countries and directed the resources to specific enforcement and intelligence goals regarding the traffic of this heroin. The scope of this intelligence and enforcement effort has included quantitative surveys of illicit opium production, identification and disruption of clandestine heroin laboratory activities, interdiction of opiates at vulnerable points along its routes, and identification and immobilization of the major international trafficking organizations involved. A concomitant goal in this activity has been to enhance the initiative and capability of DEA foreign counterparts in combatting the heroin traffic.

In addition to these special enforcement and intelligence programs, DEA is conducting narcotics enforcement training programs in critical countries in order to increase the awareness of these countries regarding the narcotics problem and to improve their narcotics enforcement capability. This program is currently concentrating on Pakistan (primary source area for opium) and Turkey (primary heroin production and trafficker source area) where, since 1980, several hundred police officials have received DEA training.

DEA-DEPARTMENT OF DEFENSE COOPERATION

Of primary concern to DEA is the threat of narcotics abuse by the approximately one half million U.S. servicemen stationed in Europe, primarily in the Federal Republic of Germany. Cooperation between DEA's five offices in Germany and U.S. military narcotic enforcement authorities is excellent and occurs on four planes: (1) enforcement cooperation, (2) intelligence exchange, (3) DEA/U.S. military/FRG working groups and (4) Training.

DEA conducts joint undercover investigations in concert with the Air Force Office of Special Investigations (AFOSI) and the Army Criminal Investigation Division (CID). These investigations characteristically involve joint funding for expenses and flashrolls, exchange of tactical intelligence, and sharing of informants. As an example, DEA is presently involved in three separate projects with CID and appropriate FRG enforcement agencies that involve the joint funding of undercover apartments. The apartments are utilized for major narcotic investigations and intelligence developed during the course of an investigation is shared jointly by all participating agencies.

The exchange of tactical intelligence is continuous. Presently, all cables involving seizures and arrests by CID level one teams in Germany are automatically distributed to the DEA Office in Frankfurt. This arrangement is further supported by frequenty liaison visits and referrals of information by DEA to CID, AFOSI, and other military agencies. DEA routinely conducts EPIC/NADDIS checks in support of U.S. military investigations.

Strategic intelligence, also, is exchanged on a regular basis, primarily through the Office of the Special Assistant for Drug Enforcement Matters (SADEM), USEUR-COM. Reports from DEA's Office of Intelligence and the Regional Intelligence Office are furnished to SADEM from where they are distributed to individual military agencies. SADEM intelligence and other reports are distributed to DEA through the Bonn District Office.

DEA actively participates and fully supports liaison and cooperation with SADEM and FRG authorities through the Central Working Group, Permanent Working Group Narcotics, and five regional working groups. This has contributed to the development of mutual policy and enforcement measures that are consistent with the overall objectives and interest of both DEA and the U.S. Military.

The U.S. Drug Abuse Initiative presented by SADEM to the NATO Military Committee in February 1980 was closely coordinated and prepared jointly with DEA. SADEM's visits to Norway, Holland, Portugal, Italy, and the FRG, in furtherance of this NATO initiative, have been coordinated fully with the respective DEA Country Attaches. In the Spring of 1980, SADEM spent almost a full week with the DEA Regional Intelligence Office, then in Paris, to exchange intelligence and observe DEA's analytical techniques.

DEA is involved in training the U.S. Military regarding narcotics enforcement through a variety of programs. In fiscal year 1980, DEA narcotics training was provided to 751 military personnel, approximately 95 percent of whom were CID personnel. To date in fiscal year 1981, 380 military personnel have been trained with the expectation that the year's total will equal or surpass that of fiscal year 1980.

Three of the above training programs for fiscal year 1980 actually occurred in Germany with a total of 133 participants. Intelligence analysts assigned to SADEM have also received DEA training, one for a full week with the Regional Intelligence Office in Paris, and one with a two week analysis course at DEA Headquarters.

In essence, the cooperation between DEA and U.S. Military agencies in Europe is excellent. The interdiction of illicit drugs to members of the U.S. Forces is an integral part of DEA's mission and relevant policies and actions are coordinated fully among the interested agencies.

CURRENT HEROIN AVAILABILITY AND THREAT TO U.S. FORCES IN EUROPE

In late 1979 and early 1980, Western Europe received the full impact of a greatly expanded heroin traffic from Southwest Asia. Among the countries hardest hit was the Federal Republic of Germany, where heroin overdose rates soared as heroin became inexpensive, plentiful and potent. Through intense efforts by the U.S. Military authorites in their drug enforcement and drug abuse prevention and treatment programs, heroin abuse by U.S. Military personnel has leveled off. Independent information available to DEA is consistent with recent Department of Defense reports regarding this situation.

For a variety of reasons, the quantity of SWA heroin presently reaching Germany appears to be on the decline. One of the indicators in this regard is seizure statistics. During the first quarter of 1980, DEA received reports of a total of 57 kilograms of SWA heroin being seized in Germany. For the first quarter of 1981, the figure dropped 68 percent to eighteen kilograms. The number of heroin overdose deaths is another primary indicator of availability. The annual number of overdose deaths in Germany peaked at 623 in 1979 and decreased 21 percent to 494 in 1980. Reports from DEA's five offices in Germany reflect local heroin price increases and purity decreases. These also are indicators of less heroin availability. In addition, pharmacy burglaries are on the rise in the German state of Baden Wurttemberg. This suggests that addicts there are in short supply of heroin and are turning to pharmacies to steal substitute narcotics.

Although DEA is encouraged by this recent trend, one must acknowledge that the potential for a significant increase in availabilty of Southwest Asian heroin exists. In addition, with the recent increased opium production in Southeast Asia, the threat of a resurgence of heroin in Europe from that source can not be discounted. For these reasons, and also to protect the United States from these threats, DEA will continue to assign a high priority to its foreign operations.

I appreciate your inquiry into this matter and share your concern regarding the impact of illicit drugs from foreign sources on the United States and on our servicemen abroad. My staff and I remain available to provide any additional information you may desire in this regard.

Yours truly,

PETER B. BENSINGER, *Administrator.*

Mr. ZEFERETTI. I would like to move things right along so we can bring in the members of the armed services, the members from the Defense Department.

At this time I would like to call Dr. John F. Beary, Assistant Secretary of Defense for Health Affairs, accompanied by Brig. Gen. William Louisell, USA, [retired] Deputy Assistant Secretary of Defense for Drug and Alcohol Abuse Prevention.

I would suggest, Dr. Beary, that first you and General Louisell testify together and then we can go further and bring in the members of the armed services as a panel together.

I think we could get a little more done in that way.

TESTIMONY OF JOHN F. BEARY III, M.D., ASSISTANT SECRETARY OF DEFENSE [HEALTH AFFAIRS]

Dr. **Beary**. Yes, sir.

Mr. **Zeferetti**. We have your statement but you can proceed. It will be made part of the record without objection, and you can proceed in any manner in which you feel comfortable.

Dr. **Beary**. Thank you, sir.

Mr. **Zeferetti**. By the way, let me say welcome. This is a new responsibility for you, I believe, as of July of this past year. We welcome you as part of, let's say, a team that is going to do, I hope, the kind of job that will have an impact on this overall problem.

Dr. **Beary**. Yes. Thank you very much.

The problem of alcohol and drug abuse in our Armed Forces just as in our society at large is one of the most serious health problems confronting young people today.

The efforts of this committee to reduce the levels of substance abuse are laudable and have assisted us in focusing command support as well as dollar and manpower resources on this menace to health and military discipline.

As the principal Deputy Assistant Secretary for Health Affairs, I am charged with oversight of a broad range of programs which include medical readiness, CHAMPUS, health planning, alcohol and drug abuse, and a number of others.

In addition, I am presently serving as the Acting Assistant Secretary until Senate confirmation of Assistant Secretary-designate Smith.

Since assuming my role at DOD on July 1, I have endeavored to become conversant with the policies and programs within the purview of health affairs. However, the past few weeks, a good deal of my attention has been devoted to developing the budget.

However, I have also spent a good deal of time reviewing the policies and programs developed by the Office for Drug and Alcohol Abuse Prevention.

I agree with the contention of the committee that the current high prevalence of drug abuse in the military is unacceptable and we have to make progress.

People who work in national defense jobs have important responsibilities which cannot be met if their alertness and judgment are compromised by the effects of drugs.

A personal interest of mine, since I am a physician and medical school teacher is technology advances such as reliable, portable urine testing devices which will assist us in discharging our duty.

Another advance which will discourage the abuse of prescription drugs is exemplified by the new computerized pharmacy system at the Navy hospital in Charleston, S.C. This system will put a hold on a prescription refill such as codeine if the patient shows up 48 hours after being given a 1 week's supply.

It will also detect a drug shopper who visits military pharmacies in the areas seeking psychoactive drugs perhaps to resell to other troops or sailors.

One advance I follow with particular interest is that of sustained-release implantable drug delivery systems. Polymers of polylactic/glycolic acid have been developed which look and feel like a piece of spaghetti.

These are placed under the skin of the patient in the doctor's office. I stress this is under development at the present time. But the theory is interesting and should be followed.

The material slowly releases medicine into the patient's body for weeks. The delivery system, itself, is absorbed as nontoxic monomers of the natural substances lactic acid and glycolic acid. Researchers at Stanford are studying sustained-release naltrexone—an analog of naloxone—for the treatment of heroin abusers.

A colleague of mine at Georgetown University is developing implantable sustained-release disulfiram for the treatment of alcoholism. Therefore, one can contemplate that for appropriately selected patients one can assure abstinence from alcohol or narcotics for 6 to 8 weeks with a single outpatient injection.

A promising new development in the detection area has been pioneered by Dr. Michael Phillips. Drugs are excreted in sweat and he has developed a sweat-patch which is affixed with security tape. If development is successful, it could be used to screen and follow up drug and alcohol abusers.

It would provide a tool analagous to dosimetry badges which are used to monitor radiation exposure.

Additional priorities include education programs which stress newly recognized chronic health effects of cannabis. Early in the seventies there was an impression among many young people that this was a benign drug which had some short-term effects but that long-term effects weren't a problem.

However, current research shows reason for concern in that regard. Memory impairment has been pretty well shown. One recent example, related to me by Dr. Bob DuPont, an expert in this field, concerned rock singers who could not remember lyrics to songs they had sung 500 or 1,000 times. And when they stopped daily use of marihuana, that memory impairment resolved to a large extent but one would still have concern as to whether there would be structural brain damage over the long term.

Carcinogenicity is another fact. A marihuana cigarette has more carcinogens than an unfiltered Camel. Alterations in reproductive physiology—decreased levels of testosterone FSH and LH—have been shown. There has also been shown to be fetal damage manifested by a four times increase in the miscarriage rate.

Recent advances in court decisions supporting law enforcement authorities such as the *Armstrong* case promise to give us new tools. So possibly the bottom line of this can be that the balance is tipped in DOD's favor and not the drug abusers.

As a physician I have a deep commitment to the treatment and prevention of health problems. I recently devoted a considerable time to learning more about alcohol and drug abuse treatment strategies at the Department of Defense Worldwide Conference.

It was gratifying to discover that DOD is attempting to use the best known principles and methods of treatment for those who require care.

Restoring, those involved with alcohol and drugs, to full duty is both easier and less costly than replacing them.

I have a very strong interest in data collection and intend to see our efforts are of sufficient quality that we can see where we are, where we are going and thus change our course in a timely fashion if we need to do so.

I think I might depart just a bit from my prepared remarks and my original strategy for simply acknowledging that there is a big problem, and point out some concerns I have because of what I would call the flak job that was done on Ike Pappas on the CBS news report he delivered last night.

I worked as a journalist myself before going to medical school and appreciate some of the problems involved in putting a story like this together and since I come from Iowa originally, where we tend to speak frankly, I would like to speak rather directly so that there is no problem with misinterpretation.

I am speaking just to the issue. I think very highly of you as individuals and your concern, the work you are doing. I simply want to give the countervailing view on this study which is the main reason we are here today.

If there weren't a study we wouldn't be here this particular day. So I think that is cogent to what is going to follow here. Anyway, Mr. Pappas' story implied that 50 percent of Navy personnel were high during duty hours. This was presented as a fact, which it isn't.

Let me tell you why. I have reviewed manuscripts for publication, am familiar with data tables, and how experiments are designed and analyzed. That is why I have to say this report would get an A for hype but scientifically it is on the eighth grade level—if that.

Fortunately, nobody's name is on it, so I can speak to the issue and not have to worry about personalities. The points I will make about this study, this select committee study, is that it is an unsubstantiated opinion poll. The error range on these numbers as best as I can estimate, because of the inadequacies of data presentation, is plus or minus 30 percent.

So when you tell me the number is 50, I tell you the number 20 and the number 80 are the same number in that spread. It is not a random study. Page 2 of your report alludes to that. It says this procedure is not strictly random.

Well, that is about like not being strictly round. It is either random or isn't.

And the last sentence would not follow from the point I just made at the bottom of that paragraph where it says, "Therefore, the survey has validity." OK. Well, some of the specific problems, I have only had the report for 48 hours but I have been trying to work on it pretty hard during that time, in your report it would not exclude somebody who had a beer at lunch at the bowling alley. One of those ships you were studying was in port, I am told for about 4 days, and daytime liberty parties were going ashore during working hours, because these guys are working 12 hours on, 12 hours off. And that would not be excluded. Others will bring out those points a bit later.

Now, I emphasize again, I am saying this because the report we did in 1980, which I am going to say a little bit about, is statistically valid. Your report is fine in terms of calling attention to something but it is not useful data for me to use as a manager.

So, in regard to this study by Dr. Marvin Burt done in 1980 it was a random study. You have to have some techniques such as selecting social security numbers at random to avoid bias because often if you are looking for something you are going to find it. That is why physicians and scientists are skeptical. We want to be able to look at data ourselves and see that it has validity, that somebody else can reproduce it and that a figure in California is the same as in New York if people are using the same tools.

The numbers here have a confidence level of 5 percent comparted to plus or minus 30 percent in your work. In addition these have been validated with urine testing information so we not only have a survey but we have chemical confirmation too.

So, what does it say in here. Our figures would be that people who are high at work in the Navy are 26 percent. The committee says 49 percent. High at work DOD-wide we say 19 percent, compared to the committee again, the data is presented so poorly it is very hard for anybody to figure out but it is, as best I can determine it is 36 percent. Therefore these things are all being exaggerated by a factor of two.

The drug problem is significant but it should not be exaggerated. The conclusions you have on page 9 are presented as fact. You can't make any conclusions from that information. You have a collection of anecdotes. You cannot prove DOD drug program is failing. In fact you show it improving by your own chart that second chart from the right over there. When General Louisell discusses details of our program we will give you more about that.

We need standards. That is what statistics are for. We agree there is a big problem but if I am measuring it with a 3 foot yardstick and yours is 6 feet long we will never get anywhere or be able to talk to each other. Those of you that have had a statistics course have no difficulty following my point. Those who haven't need a lecture on sampling techniques and data analysis.

In summary, I think it is a disservice to men in uniform by implying that 50 percent of them are high on duty without evidence. There are a lot of good people being besmirched in that statement.

Mr. ENGLISH. Is the gentleman saying——

Dr. BEARY. This is the only time I will have to make my point in an uninterrupted fashion. The reason I am stimulated to say this, again because people with stature like Ike Pappas who is an experienced journalist took the handout like he was your PR man or something and put across to the public last night the impression that 50 percent of the Navy are potheads.

So that there is no possibility of misinterpreting my position to the Select Committee—again it is the study not you as people or your intentions which I criticize. We need a counterview and that is why I am here.

As a document for planning and programing my professional assessment is in conclusion, one, it has an error rate of about 30 percent, and two, it should be placed in file 13. Like many health problems substance abuse is complex and won't be solved overnight. What the irreducible minimum is I don't know. I do know however we have not achieved it yet. I am convinced that continued high level support for our effort coupled with systematic, vigorous leadership will continue to yield progress in reducing the impact of alcohol and drug abuse on the effectiveness of our forces.

I assure you that this program has and will continue to have my full personal support and interest. General Louisell will discuss the details of our program in his statement.

Thank you.

[The prepared statement of Dr. Beary follows:]

Prepared Statement of John F. Beary III, M.D., Principal Deputy Assistant Secretary of Defense (Health Affairs)

Thank you for the opportunity to appear before the Select Committee. The problem of alcohol and drug abuse in our Armed Forces, just as in our society at large, is one of the most serious health problems confronting our young people today. It is also a very expensive problem. The efforts of this Committee to reduce the levels of substance abuse are laudable and have assisted us in focusing the command support as well as dollar and manpower resources on this menace to health and military discipline.

As the Principal Deputy Assistant Secretary of Defense for Health Affairs, I am charged with oversight of a broad range of programs which include medical readiness, Champus, health planning, alcohol and drug abuse, and a number of others. In addition, I am presently serving as the Acting Assistant Secretary of Defense for Health Affairs until Senate confirmation of the Assistant Secretary-Designate.

Since assuming my role at the Department of Defense on July 1, 1981, I have endeavored to become conversant with the policies and programs within the purview of Health Affairs. For the past several weeks, much of my attention has been devoted to the budget planning process. However, I have also spent considerable time reviewing the policies and programs developed by the Office of Drug and Alcohol Abuse Prevention. The current high prevalence rates of alcohol and drug abuse are unacceptable, and I take no comfort in knowing that our prevalence rates mirror those in the civilian community. People who work in national defense jobs have important responsibilities which cannot be met if their alertness and judgment are compromised by the effects of drugs.

Technology advances such as the development of more reliable portable urine testing devices will assist us in discharging our duty. An advance which will discourage the abuse of prescription drugs is exemplified by the computerized pharmacy at the naval hospital in Charleston, S.C. This system will put a hold on a prescription refill such as codeine if the patient shows up 48 hours after being given a one week supply. It will also detect a "drug shopper" who visits other military pharmacies in the area seeking psychoactive drugs. One advance I am following with interest is sustained-release implantable drug delivery systems. Polymers of polylactic/glycolic acid have been developed which look and feel like a piece of spaghetti. When implanted under the skin in a doctor's office, the material slowly releases medicine into the patient's body for weeks. The delivery system itself is absorbed as nontoxic monomers of the natural substances lactic acid and glycolic acid. Researchers at Stanford are studying sustained-release naltrexone (an analogue of naloxone) for the treatment of heroin abusers.

A colleague at Georgetown University is developing implantable sustained release disulfiram for the treatment of alcoholism. Therefore one can contemplate that for appropriately selected patients one can assure abstinence from alcohol or narcotics for 6 to 8 weeks with a single outpatient injection.

A promising new development in the detection area has been pioneered by Dr. Michael Phillips. Drugs are excreted in sweat and he has developed a sweat-patch which is affixed with security tape. If development is successful, it could be used to screen and follow up drug and alcohol abusers. It would provide a tool analagous to dosimetry badges which are used to monitor radiation exposure.

Additional priorities include education programs which stress newly recognized chronic health effects of cannabis such as memory impairment, carcinogenicity (a marijuana cigarette has more carcinogens than an unfiltered Camel), alterations in reproductive physiology (decreased levels of testosterone FSH and LH), and fetal damage (four times increased miscarriage rate).

Recent advances in court decisions supporting law enforcement authorities, promise to give us new tools so that the balance can be tipped in DOD's favor rather than the drug abusers.

I have a strong interest in data collection and analysis and intend to see that our efforts are of sufficient quality that we can see where we are, where we are going and thus change our course in a timely fashion if we need to do so.

As a physician, I have a deep commitment to the treatment as well as the prevention of health problems. I recently devoted a considerable time to learning more about alcohol and drug abuse treatment strategies from a number of nationally recognized experts at the Department of Defense Worldwide Conference. It was gratifying to discover that Department of Defense health care professionals are employing the best known principles and methods of treatment and rehabilitation for those who require care because of substance abuse. Restoring, those involved with alcohol and other drugs, to full duty is both easier and less costly than replacing them.

Like many health problems, substance abuse is complex and won't be solved overnight. What the irreducible minimum is I do not know. I do know, however, that we haven't achieved it yet. I am convinced that continued high level support for our effort coupled with systematic, vigorous leadership will continue to yield progress in reducing the impact of alcohol and drug abuse on the effectiveness of our Armed Forces. I assure you that this program has, and will continue to have, my full personal support and interest. Brig. Gen. Louisell will discuss the details of our program in his statement.

Mr. Zeferetti. Go ahead.

TESTIMONY OF BRIG. GEN. WILLIAM C. LOUISELL, USA (RETIRED), DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR DRUG AND ALCOHOL ABUSE PREVENTION

General Louisell. I will summarize my written testimony.

We thank you for the opportunity to appear before the House Select Committee. This committee has served the country and its Armed Forces well by insuring that, in our press to generate fighting forces responsible to the national interest, we do not forget the essential human ingredient.

The American taxpayers have a right to be assured that the people who command, control, man, and maintain expensive weapons systems are disciplined, combat ready, and competent. Substance abuse attacks that readiness; it must be suppressed.

Substance abuse is endemic in American society; it is endemic in the American Armed Forces manned by the youth of that society. The national high school class of 1980 reports that almost three out of four have used alcohol in the past 30 days—recent use—and one out of three have used marihuana in the past 30 days.

Indeed, 6 percent use alcohol daily and 9 percent use marihuana daily. This then is the substance abusive environment—the homes, neighborhoods, schools, and other institutions—from which our recruits report for induction.

Parenthetically, we are not saying that our social institutions condone substance abuse. Quite the contrary, they universally disapprove of and disavow such behavior. The point is that this endemic substance abusive behavior occurs in spite of the sanctions of the social institutions which are supposed to influence the 18-year maturation process that occurs before an American citizen volunteers to serve in the Armed Forces.

What is the substance-abuse situation in the Armed Forces? It is almost the same as it is among their civilian counterparts. For instance: 84 percent of our 18- to 25-year-old service members report drinking alcohol in the past 30 days; 82 percent of like civilians drink alcohol. Forty percent of our 18- to 25-year-old military members have used marihuana or hashish in the past 30 days; 42 percent for like civilians. Seven percent of young service members have used cocaine in the past 30 days as opposed to 10 percent for like civilians. A complete comparison is attached for the record.

Various useful statistics on substance abuse are available, including this committee's samplings taken in Europe in 1978 and 1981. The committee's figures are useful. They show that alcohol and cannabis use have been reduced 10 percent in the E1 to E4 population, cocaine—44 percent, heroin—60 percent; downers—48 percent; PCP—40 percent; assorted other drugs—40 percent and use of amphetamines has increased 2 percent.

These figures, while encouraging, do not tell the whole story. Substance abuse in the 18- to 25-year-old age group in many cases is polydrug abuse, with almost half reporting they mix alcohol and cannabis. This means that DOD cannot separate alcohol from drug abuse prevention efforts. Because alcohol is the drug of choice among older service members, alcohol abuse prevention programs must be effective to give credibilty to the drug abuse prevention effort aimed at the 18- to 25-year-old members of the Armed Forces.

Prevalence rates are useful, but the consequences, and the effect upon individual combat readiness, of substance abuse in the Armed Forces are more pertinent. We have looked at those consequences; the results are not reassuring.

Seven percent of the Armed Forces reported they were alcohol dependent. Four percent reported themselves drug dependent. This equates to at least 130,000 members of the Armed Forces who were substance dependent last year.

Nine percent of the E1–E5 population reported they were high on drugs at work 40 or more times in a year; 2 percent of all service members reported they were high/drunk on alcohol at work 40 or more times in a year.

One out of five service members reported lowered performance on duty due to alcohol and 1 out of 10 E1's to E5's reported lowered performance as a result of drugs.

The facts I have recited are only the highlights of a DOD worldwide assessment made in 1980, primarily at the urging of this committee. The complete survey was provided to the Congress on 13, November 1980 and the executive summary is provided for the record. Some additional conclusions we draw from the survey are. Alcohol is the most serious threat; marihuana/hashish is the second most serious threat; the continental United States is the geographical area of highest abuse for most substances; service members ages 18 to 25, grades E1–E5, are the predominant substance abusers for both alcohol and drugs; the major form of abuse is polydrug abuse; young heavy drinkers are also heavy drug abusers.

We believe we have a clear, reasonably accurate view of the substance abuse situation in the Armed Forces. The Department of Defense has looked the problem squarely in the eye, and what we see does not make anyone comfortable. Our combat readiness is affected. Not only by the degrees of impairment noted previously, but also by the secondary effects of individual substance abuse on teamwork, respect for authority, mutual confidence, unit cohesion, quality of service life, and the diversion of resources to combat the threat. The Department of Defense needs no further motivation to press the attack on the problem of substance abuse.

What are we doing about it?

First, we have stated as fundamental policy a complete intolerance for the abuse of alcohol, the possession, trafficking and use of drugs on or off duty by military members and on the job by our civilian employees. Paraphernalia is equally prohibited; installation commanders have been directed to identify local civilian head shops and put them off limits if necessary. This basic DOD directive, enclosed in our formal statement, also established the functional areas of the prevention program and organizes the DOD effort along those functional lines. I would like to touch on each of those functional areas and what we are doing in each.

Assessment of the problem is the key to focused action, resource allocation and, most importantly, command awareness. The DOD worldwide survey of 1980 is the keystone of the assessment effort; it will be repeated biannually. To keep abreast of trends we receive, and disseminate to the Department and other Government agencies, reports of recruiting rejections, urinalysis results, exemption applications, deaths, treatment/rehabilitation entries, discharges, UCMJ actions and intelligence from our laboratories. This data is assessed and each quarter forwarded to DEPSECDEF and the services.

In 1982, we will extend our survey to our civilian employees and our dependent high school students will be included in the NIDA annual survey for 1982. After 2 years of searching for better ways, the Department as a whole is about to streamline and improve our trend data system. We will hit the street in January 1982 and we will be under the new system by next July.

Our commanders are, by nature, problem solvers. They must first be convinced there is a problem: the Worldwide Survey results have been an effective tool in convincing senior officers that the problem is indeed endemic.

DETECTION AND DETERRENCE

The key elements of our policy initiatives in this area include urine testing, antismuggling, narcotics intelligence and interdiction, and military law enforcement programs.

Urinalysis has been in use since the Vietnam war and has had some success in detecting and deterring hard drug use. Starting October 1 of this year the services will be deploying a number of field portable kits to the operating units. One version of the kit can detect cannabis. Concurrently, our eight laboratories, which must verify all positive urine samples, will begin testing 10 percent of all samples submitted for cannabis. If this "pulse" testing proves out, we will be able to test routinely at the labs for cannabis.

It may now be possible to use properly taken urine results as evidence in military justice proceedings. This combination of technology and law will provide commanders with powerful tools to both detect and deter drug abuse. It will remain up to them, how and when to use them. The Department has published a proposed change to our discharge policy. The proposed change eliminates the requirement for an honorable discharge when separation is based upon evidence of mandatory urinalysis. Instead, the character of discharge will be based upon the character of service which may include discharge under other than honorable conditions. This should remove the inequity which now permits service members who, through their own volition, will not accept help to get the same rewards as those who do their duty well and faithfully.

The Department runs the largest and most complete rehabilitation system in the world. Rehabilitation is available to every military member. We are approaching that for dependents and have a way to go in the civilian employee area. These resources range in sophistication from the vital counseling role of sergeants and captains to full-time residential facilities of the first rank in professional competence.

Again, the committee's July sampling is useful. Fifty-seven percent of the soldiers in Europe, whether or not they were participants, rated the treatment rehabilitation program fair to excellent. The figure for the Navy is 65 percent, 71 percent for the Marines of the 6th Fleet, and 65 percent for the Air Force sample.

I cannot overemphasize the role of junior leadership in combating this problem. I agree with the professionals who say that substance abuse is primarily adolescent behavior that will respond most quickly, and most cheaply, to firm, sensitive discipline, challenging demanding jobs and a reasonable quality of life on and off duty. The tough decision as to when to discharge the substance abusing service member who cannot or will not be rehabilitated, must be left to the lowest level of command. That level of command must first be in place; second, be armed with appropriate authority and third, be backed up with procedures that guarantee the individual is given a fair chance.

In the research on substance abuse, DOD has had some substantial influence. Portable urinalysis kits with a cannabis reagent and the development of cannabis detection capability with existing laboratory equipment are examples. The blood chemistry research jointly being conducted by DOD and NIDA is very important and is being pushed.

As I have said, the Department has looked at this problem squarely and honestly. We have done so at some risk. The highest purpose of the Armed Forces is to deter war. Deterrence must be both actual and perceived. If a potential enemy perceives weakness, deterrence is degraded. When we publicly illuminate a situation which degrades readiness, we also degrade the perception of combat readiness.

In addition, careless extrapolation of substance abuse statistics can and has resulted in the besmirching of the pride, self-confidence and demonstrated abilities of thousands of superb soldiers, sailors, marines, and airmen serving in hundreds of tough, fighting-ready battalions, men of war and aircraft.

At the beginning of this statement, much was made of the similarities between substance abuse prevalence among the youth of our society and the youth of our Armed Forces. Make no mistake, the Department of Defense, from Secretary to sergeant major, takes no comfort in that similarity.

The Armed Forces serve in a high-technology, fast-paced, and often dangerous environment. The soldiers, sailors, marines, and airmen who are not in full control of their mental and physical faculties, due to their own misconduct, are failing in their duty and are a threat to their comrades in arms.

We have a comprehensive, multifaceted program to reduce the abuse of alcohol and drugs. Our commanders are by nature problem solvers and they have lots of problems to solve. Substance abuse prevention is not always their first priority every day; they have complicated, multifaceted missions. Abusive behavior is not always a cause of ill discipline and poor performance, it is just as often a symptom of other problems embedded in the unit's mission and quality of life. Progress is slow; there are no magic bullets.

The Department, like society, will always be able to do more and do it better. With the support and encouragement of the Congress we will persevere in our attack on this insidious threat to our people and our society.

[The prepared statement of General Louisell follows:]

PREPARED STATEMENT OF

BRIGADIER GENERAL WILLIAM C. LOUISELL, USA (Ret.)

DEPUTY ASSISTANT SECRETARY OF DEFENSE
FOR DRUG AND ALCOHOL ABUSE PREVENTION
(HEALTH AFFAIRS)

We thank you for this opportunity to appear before the House Select Committee. This Committee has served the country and its Armed Forces well by insuring that, in our press to generate fighting forces responsive to the national interest, we do not forget the essential human ingredient. At a time in our history when we, the Department of Defense, are trying in a responsible way to redress the military balance in a dangerous world, the American taxpayers have a right to be assured that the people who command, control, man, and maintain the expensive weapons system are disciplined, combat ready and competent. Substance abuse, alcohol and drug abuse, attacks that readiness, that discipline, that competence; it must be suppressed.

Substance abuse is endemic in American society; substance abuse is endemic in the American Armed Forces manned by the youth of that society. The national high school class of 1980 reports that almost three out of four have used alcohol in the past thirty days ("recent use") and one out of three have used marijuana in the past thirty days. Indeed, six percent use alcohol daily and nine percent use marijuana daily. This then is the substance abusive environment - homes, neighborhoods, schools, and churches - from which our recruits report for induction.

Parenthetically, we are not saying that such social institutions as homes, neighborhoods, schools and churches approve of substance abuse. Quite the contrary, they universally disapprove and disavow such behavior. The point is that this endemic substance abusive behavior occur in spite of the sanctions of the very social institutions which are supposed to influence the 17 to 18 year process of maturation that occurs before an American citizen volunteers to serve in the Armed Forces.

What is the substance abuse situation in the Armed Forces? It is almost the same as it is among their civilian counterparts. For instance: 84% of our 18-25 year old service members report drinking alcohol in the past 30 days; 82% of like civilians drink alcohol. Forty percent of the 18-25 year old military have used marijuana in the past 30 days; 42% for like civilians. Seven percent of young service members have used cocaine in the past 30 days; ten percent of the 18-25 year military reporting "recent use" and four percent for like civilians. A more complete comparison is shown in Table V-1 from the 1980 DoD Worldwide Survey which is attached for the record (Tab A).

Various useful statistics on substance abuse statistics are available, including this Committee's sampling taken in Europe in 1978 and 1981. As disquieting as these prevalence numbers are they do not tell the whole story. Substance abuse in the 18-25 year old age group in many cases is poly drug abuse. Those who abuse substances in the Armed Forces are chemical gourmets. Almost half report they mix alcohol and cannabis and 16% reported mixing cocaine with alcohol. The effects of such witches brew are unpredictable and dangerous. To the Department of Defense this fact means that we cannot separate alcohol and drug abuse prevention. Indeed, because alcohol is the drug of choice among the older service members, the leadership, alcohol abuse prevention programs must be visible and effective to give credibility to the drug abuse prevention effort aimed at the 18-25 year old members of the Armed Forces.

Prevalence rates are useful but the consequences of substance abuse in the Armed Forces are most pertinent. We have looked at the consequences of substance abuse in the Armed Forces. The results are not reassuring:

- Seven percent of the Armed Forces reported they were alcohol dependent. Four percent reported themselves as drug dependent. This can be dramatized by saying that there were at least 130,000 members of the Armed Forces who were substance dependent last year!

- Nine percent of the E1-E5 population reported they were high on drugs at work 40 or more times in a year; two percent of all service members reported they were high/drunk on alcohol at work 40 or more times in a year. This percentage can be translated to say that there were at least 170,000 Soldiers, Sailors, Marines and Airmen on the firing ranges, in the maneuver areas, on the decks and in the maintenance shops who were high or drunk 40 or more times last year!

- One out of five service members reported lower performance of duty due to alcohol abuse and one out of ten E-1's to E-5's reported lowered performance as a result of drug abuse.

The facts recited above are only the highlights of a DoD Worldwide Assessment made in 1980 primarily at the urging of this Committee. The complete survey was provided to the Congress on

24 November 1980 and the Highlights volume is attached for the record (Tab B). Some additional conclusions we have drawn from the Survey are:

- Alcohol, among all drugs, is the most serious threat.
- Marijuana is the second most serious threat.
- Continental United States is the geographical area of highest abuse.
- Service members ages 18-25 (grades E1-E5) are the predominant substance abusers, both alcohol and drugs.
- The major form of abuse is poly drug abuse, combining alcohol and other drugs, i.e., young heavy drinkers are also heavy drug abusers.

We believe we now have a clear, reasonably, accurate view of the substance abuse situation in the Armed Forces. The Department of Defense has looked the problem squarely in the eye. What we see does not make anyone comfortable. Our combat readiness is affected. Not only by the degrees of impairment noted previously but also by the secondary affects of individual substance abuse on team work, respect for authority, mutual confidence, unit cohesion, and the general atmosphere of order and discipline. The Department of Defense needs no further motivation to press the attack on the problem of substance abuse.

What has preceded is a fair statement of the problem. What is the Department of Defense doing about it?

First, in execution of its proper role, the Department of Defense has set as a goal to be free of the effects of substance abuse. We have proscribed the possession, sale and use of drugs and drug paraphernalia by members of the Armed Forces at anytime and by Department of Defense civilian employees at work. We have organized and established policy in the functional areas of substance abuse Prevention, Assessment, Detection and Deterrence, Education and Training and Treatment and Rehabilitation. We are organized in the Office of the Secretary of Defense to develop, promulgate and supervise the execution of policies in each of those areas, and we have tasked the Military Departments and the DoD agencies to establish and operate programs in execution of those policies.

The pertinent document is Department of Defense Directive 1010.4 dated 25 August 1980 which is attached for the record (Tab C). The ensuing paragraphs enumerate in detail DoD policy and program in each functional area. This entire body of policy is a natural progression of what has been learned over the years, policy initiatives discussed before this committee in previous hearings, and certain new initiatives which resulted from the growing supportive technology, developments in the applications of the law. We will never reach our stated goal; if we do it will be a first in recorded military history!

To conduct our drug and alcohol abuse control programs, DoD spends about $100 million annually. We employ approximately 3900 persons full time in drug and alcohol abuse prevention and rehabilitation programs. In addition, at least three times that number spend part of their time working with the program.

ASSESSMENT

Budget, policy and program decisions should flow from a firm baseline of knowledge. To provide this baseline in the drug and alcohol abuse area the DoD operates a complex, accurate program of assessment. This assessment program is divided into two primary areas of concern: (1) the prevalence or extent of abuse in the population (the long term situation), and (2) the trends of abuse (the short term). The data to satisfy the prevalence and trend requirements are different. They are gathered from different sources, by different means, at different frequencies, and are analyzed differently to yield their respective results. These results are then used to modify budget, policy and program activity.

Prevalence, the first of the two assessment functional areas of interest, is concerned with the extent of drug and alcohol abuse in the military population. This is the number of servicemembers who are users of drugs or alcohol. The DoD also couples, consideration of work impairment due to drug and alcohol use and consequences of use, with prevalence. The data for each functional area are collected at the same time and by the same means. The objectives of the investigations into prevalence are shown below:

- Determine the prevalence of drug and alcohol abuse within the military using categories of abuse defined in terms of physical, social, and work consequences, and physical and psychological dependence.
- Determine the nature of drug and alcohol abuse in the military in terms of demographic characteristics and behavioral factors.
- Compare drug and alcohol abuse high risk subpopulations within the military to similar subpopulations of civilians.

- Assess the effects of drug and alcohol use on the servicemember's personal well-being and military job performance through self-reported consequences.
- Determine the social climate involved in the use of drugs and alcohol and the servicemember's admitted reasons for using drugs and alcohol.

The purpose for collecting prevalence, work impairment and consequences information are several. The DoD wishes to know the extent of impairment and use consequences to provide some measure of the effect that abuse has on a unit's effectiveness in functioning in its assigned role. Prevalence data are required to make judgments on the populations that must be reached by education programs, such as how those education programs should be projected and at what stage in the servicemember's career those programs are most effective. Prevalence data are also used in treatment program preparation. It is necessary to know the size of the population requiring treatment, so that the treatment program can be tailored to the population at risk. Finally, the prevalence data is required as a basis for making budgetary recommendations and decisions. Knowledge of the extent of the using populations is required when calculating costs in the budget cycle of the identification, education, treatment and rehabilitation, training, evaluation, planning and coordination, and research aspects of the abuse program. Finally, the prevalence data are useful in making epidemiological comparisons with the extent of drug and alcohol abuse in the civilian sector.

The DoD has elected to obtain prevalence data of its military population through the medium of an anonymous, group administered, personnel survey. This survey seeks information of both drug and alcohol use. The last such survey was conducted in the Spring of 1980. The survey was planned, organized and administered by a contractor, Burt Associates, Inc. It was stipulated by the DoD that a sample be drawn of all active duty military personnel throughout the world from which reliable estimates of drug and alcohol use could be made with known degrees of error for each of the military services. It was to include five pay grade groupings (E1-E5, E6-E9, W1-W4, 01-03, and 04-06), and four main geographical regions (Continental United States, Europe, Pacific and Other Locations). It was further stipulated that the response rate among sampled personnel be 80 percent or higher, without replacement.

The first step in the survey procedure was the development of the questionnaire to be used. A questionnaire that had been used by a respected contractor in a previous survey was selected as the basic document. Some changes were necessary because that survey treated only drug abuse and some objectives were different from those now set. Alcohol questions from another tested survey were added to the basic document and the whole was modified by the current contractor so that the final design would satisfy the stated objectives of the survey.

All questions were designed to require distinct answers. That is, there were no open-ended, abstract, or opinion seeking questions. Each question had to be answered with a straightforward, discrete response. These answers then provided a firm, clear, unambiguous set of basic data upon which to conduct an analysis.

Upon completion of the instrument revision by the contractor, it was submitted to an independent panel for further review. This panel was composed of widely known, acknowledged experts in the field of drug and alcohol abuse surveys. Their comments were considered and the questionnaire was then submitted to a four-service pre-test. It was slightly revised once more in light of comments received from the pre-test respondents. Then, and only then, did the DoD and the contractor consider the survey instrument adequate for survey use.

Because of budgetary and time constraints, it was not possible to survey every servicemember in each of the over 300 military locations throughout the world. These considerations dictated a design that sampled both personnel and locations by probability means. A stratified multi-stage probability sample was subsequently developed and implemented. Differential personnel sampling rates were used to obtain sufficient sample sizes in the various respondent subgroups to guarantee the validity of mathematical extrapolation of the respondents responses to the military population as a whole. Sample weighting procedures were applied to put the complete respondent sample into balance. The final sample was composed of 19,582 military personnel stationed at 81 installations worldwide. An installation was composed of all permanent parent and tenant units at a base, post, camp, station or ships in a designated location.

At each randomly selected survey site, a random sample was drawn from the most current listing of all personnel assigned to the installation. The random selection was made from all personnel in pay grades E1 through 06 of the one designated service permanently assigned to organizations included in the specified installations. The last two digits of the individual's Social Security Account Number were used as the device for random selection of the respondents. Not included in the population base from which a sample was drawn, were those personnel in recruit or basic training and those personnel in units known or expected to be at sea or deployed away from the installation at the time of the questionnaire administration. Personnel selected for the sample could be excused from questionnaire administration only for the following reasons:

- on leave from the parent organization
- on temporary duty away from the installation
- absent without leave
- assigned a permanent change of station
- separated from the service

Having drawn the sample, the next task was to administer the survey questionnaire. This was done at the 81 selected sites by civilian two-man teams employed by the contractor. Civilian teams, rather than military were used to eliminate any bias which might occur by having possibly intimidating military supervisory personnel present when the questionnaire was administered.

The sample drawn consisted of 19,582 servicemembers. Of these, 16,355 were available to survey and 15,268 responded to the survey for a response rate of 93 percent. There were 1,054 who failed to appear for the survey and 33 who refused to take it.

The data were next collected, optically read and edited to delete any aberrations or obviously false data. The clean data were then analyzed by the contractor. The interpretations formulated by the contractor were next submitted to a non-government acknowledged panel of experts in the field for review and comment. The analysis was found to be valid whereupon the survey results were published and released to the public.

Survey results were published in two volumes. The first is a comprehensive report containing a full set of tables, the methodology, technical discussions and a comparison to the drug and alcohol situation in civilian society. This volume received a relatively restricted distribution. It went to the military services, the White House, selected Congressional committees, applicable agencies in the Government, and libraries. The second volume was briefer, smaller in size, contained only the most essential data, and was intended for unrestricted distribution to whomever was interested. To date this volume has had three printings. About 3,000 copies have been provided to individuals and offices worldwide.

Trends in abuse, the second of the two assessment functional areas of interest, is concerned with changes in the drug and alcohol abuse picture which may appear as differences in availability of drugs or the habits of the abusers. To detect trends, a large set of reports or data elements of drugs or alcohol are monitored for indications of change. Following is a listing of these data elements:

Report Data	Periodicity	Universe
Armed Forces Examining and Entrance Station rejections	quarterly	all prospective recruits
Drug abuse urinalysis confirmations	quarterly	all servicemembers
Exemption applications	quarterly	all servicemembers
Treatment/rehabilitation entries	quarterly	all servicemembers
Deaths	quarterly	all servicemembers
Discharges	quarterly	all servicemembers
Uniform Code of Military Justice actions	semi-annually	all servicemembers
High risk drugs seen in urinalysis laboratories	monthly	all servicemembers
Armed Forces Institute of Pathology findings	daily	all servicemembers
Personnel Reliability Program decertifications	annually	PRP personnel

In addition to these specialized data, other sources of generalized information are monitored for information of value. These include the general news media, clipping service, intelligence reports, and reports emanating from the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Drug Enforcement Administration.

All available source data are continually monitored and a brief quarterly summary is written for the Deputy Secretary of Defense calling his attention to items of interest that have arisen during the quarter. A sample report is attached for the record (Tab E). Of course, events requiring immediate attention are attended to on an expeditious basis.

It was the continuous monitoring of available indicators that led the DoD in 1979, to forecast a sharp rise in cocaine use in the Armed Forces. The services were alerted and urinalysis laboratories were directed to test for cocaine. As a consequence, when the availability and subsequently the use of cocaine began to rise, the military services were prepared. The laboratories were ready to test for it and treatment facilities were prepared to treat those detected.

At the present time there is a great deal of concern that Southwest Asia heroin with its higher purity will prove a danger to the military services. It is known to be distributed throughout Europe and the eastern United States. Is it being used by military servicemembers? To learn this, all urinalysis laboratories now submit a monthly report of the number of heroin positive urine samples seen. Knowing the geographic area serviced by each laboratory and monitoring the rise or decline in heroin positives seen, it can be determined if SWA heroin is infecting the Armed Forces. Clearly, some is being used in Europe but the amount of heroin used there seems to be on a decline. Moreover, in the eastern United States so far, there does not appear to be a significant change in heroin use.

Cocaine and phencyclidine are also included in the laboratories monthly reports. Both drugs are dangerous, which made it necessary to see if and where they were appearing in the military picture. The appearance of cocaine was discussed above and is now being seen in Europe, the western United States, Hawaii and Panama. On the other hand, Phencyclidine seems to be losing its popularity.

Relatively little of it is being seen where the United States has military forces stationed.

At present, the DoD is watching what may develop into a new drug fad. There have been reports from Los Angeles of drug users using a combination of Doriden (a sleep preparation) and codeine, which is alleged to produce a high similar to that of heroin. A summary of the Doriden/codeine situation is being prepared for the DoD, the laboratories have been queried to see if they can test for it, and if appropriate, an alert will be issued to the military services describing the drug and the effect they produce.

The DoD is concerned about the use of drugs or alcohol by those working around or flying aircraft. Consequently, all toxicology reports prepared by the Armed Forces Institute of Pathology on fatal and non-fatal aircraft accidents and incidents are reviewed to determine if there is a significant number of instances of drugs or alcohol found in the subject's systems. Fortunately, there are few.

Drug and alcohol abuse discharge data are studied to determine what abuse costs the services in terms of manpower. Two peaks have been seen in this category, one in 1971 when 8,818 were discharged for drug use and one in 1977 when 6,380 were discharged. The total now is down significantly. In 1980, 4,322 were administratively discharged for drug use.

Personnel Reliability Program (PRP) decertification figures are also monitored. PRP persons are those associated with sensitive tasks, e.g., tasks associated with nuclear weapons. Servicemembers may be separated from PRP duties, i.e., decertified, for any one of a number of reasons. The reason for the most decertifications from the program is substance abuse. In 1980, 5,324 were decertified from the PRP population. Of these, 1,726 were decertified for drug abuse and 599 for alcohol abuse. The total PRP population at the end of 1980 was 111,637.

Through day-to-day analyses of the data that is available to the DoD, we are able to detect trends, fads, and aberrations in the drug scene.

In addition to the current assessment work underway there are a number of new initiatives being undertaken, initiatives which when completed will provide an even better picture of the drug and alcohol abuse situation in the military family. Those are described below.

The extent of the problem in the active duty military force is known. What then is the extent of the problem among the military dependents? Consideration was given to surveying the dependent population, but such a survey would have to be done on a household interview basis and that proved to be too expensive for serious consideration. A less expensive alternative was to use the results of the 1979 National Institute on Drug Abuse (NIDA) household survey in the civilian population. Those results were felt to be representative of the military dependent population making. A separate dependent survey redundant and not cost effective.

Such was not the feeling with dependent school children overseas. There is concern that the overseas drug abuse atmosphere will adversely affect their development and it was decided to survey dependent high school seniors in overseas dependent schools. There are several reasons for choosing the senior year of high school as an optimal point for monitoring the drug use and related attitudes of youth. First, the completion of high school represents the end of an important developmental stage in this society, since it demonstrates both the end of universal public education and, for many, the end of living in the parental home. Therefore, it is a logical point at which to take stock of the cumulated influences of these two environments on youth. Further, the completion of high school represents the jumping-off point from which young people diverge into widely differing social environments and experiences. The last year of high school constitutes the final point at which a reasonably good sample of an age-specific cohort can be drawn and studied economically.

The DoD is engaged in studying the high school population in cooperation with the National Institute on Drug Abuse. NIDA awards a yearly grant to the Institute for Social Research at the University of Michigan to study student drug use in the United States. The DoD has transferred sufficient funds to NIDA to add to the 1982 grant to the ISR for the ISR to include a representative sample of overseas dependent schools in the 1982 survey of student drug use.

The major topic to be treated is the current prevalence of drug use among American high school seniors. Also reported are data on grade of first use, trends in use at earlier grade levels, intensity of drug use, attitudes and beliefs among seniors concerning various types of drug use, and their perceptions of certain relevant aspects of the social environment.

Civilian employers of the DoD comprise the last group that make up the DoD family. Drug and alcohol abuse in this group is also of concern. Once again, before programs can be tailored to the need, the real scope of the problem must first be determined. Accordingly, a contract has been let to conduct a survey of civilian employees of the DoD to determine the prevalence and consequences of abuse among that population. This survey is a mail-out survey and will question respondents in the United States and at the many military installations overseas. The results are due in November 1982.

In addition to the civilian survey the DoD is contributing funds to and participating with the Office of Personnel Management in an OPM sponsored study of Employee Assistance Programs (EAP). These are programs designed to assist employees who are troubled with drug or alcohol abuse, mental health, stress, or other problems. OPM, DoD and NIAAA, who is also contributing to the project are now in the process of selecting a contractor. It is planned that the contractor will examine eight EAP's, four of which will be DoD EAP's, to determine what makes good programs good and what inhibits good programs. The contractor will also do a cost analysis.

The next assessment project of interest is the forthcoming survey of the military force. The next one will be done in 1982. The work to select a contractor and proceed has begun. The objectives of this survey will be compatible with those of the 1980 work, and the results will be used to extend the time line which was initiated in 1971 and which now extends through 1980.

Finally, the trends data base is in the process of expansion. A new DoD Instruction (DoDI) on the subject of drug and alcohol abuse reports is in the final stages of DoD preparation. This DoDI expands the drug and alcohol use data receivable in the following areas:

- Recruits rejected at the AEEES
- Servicemembers identified as drug or alcohol abusers
- Results of urine testing
- Treatment/rehabilitation entrees

It also requires new drug and alcohol data pertaining to:

- Law enforcement activity
- Accidential death or injury, property damage, and motor vehicle accidents.

In addition to revising the reports system, the manner of reviewing the reports data is in the process of change. With the expanded data being received in the Office of Drug and Alcohol Abuse Prevention, an expanded method of reviewing and analyzing the data is required. Therefore, the office is also proceeding with the development of a sophisticated, automated review and analysis effort. The equipment has been received and the planning phase is underway.

The assessment arena is dynamic. There is a constant flow of data and information which one must study and from it extract the facts necessary to set policy and organize programs. Anonymous personnel surveys play a large part in information gathering but the part played by the review and analysis of the myriad of other data bits which flow through the assessment group cannot be discounted. Surveys and trend data together provide the input for a successful assessment effort.

DETERRENCE AND DETECTION

Although assessment will provide the DoD with data about the military population as a whole, detection efforts are necessary to pinpoint individuals who are substance abusers. Deterrence efforts are geared to prevention and hindering the illegal transfer of drugs. We are working to deter and detect both alcohol abuse and drug abuse. We start at the accession point and follow through at all levels of command. The key elements of our detection and deterrence effort include urine testing for illicit drugs; anti-smuggling, intelligence, and interdiction efforts; and internal military law enforcement programs, and general policies to enhance good order and discipline.

At the accession point, recruiters do the initial screening of prospective enlistees. Background checks are accomplished during the induction process. At the Armed Forces Entrance and Examining Stations (AFEES) recruits are medically evaluated and screened. Our procedures appear to be effective in screening out chemically dependent persons, i.e., addicts and alcoholics. However, we are aware that we induct former drug experimenters and users. Our recruits are a young and healthy group, and the effects of drug and alcohol abuse at this point in their lives simply does not show up in any medically recognizable way. Our urine tests have revealed that very few have illicit drugs in their system at the time of induction. We are involved in a project with the National Institute on Alcohol Abuse and Alcoholism to develop a blood test for alcoholism and drug addiction. If this materializes, and it looks promising, we will consider using this test at the AFEES.

Our urine testing program is a key ingredient in the deterrence and detection effort. We test for six illicit drugs routinely (opiates, amphetamines, barbiturates, cocaine, methaqualone, and PCP), using eight drug testing labs around the world. We analyze over half a million urine samples per year. DoD is presently working on identifying a urine test for marijuana which meets our needs. In fact, a test of marijuana reagent will begin 1 October 1981. We are also quite pleased with the fact that the Armed Forces Institute of Pathology laboratory was able to develop a confirmatory test for marijuana which uses current DoD laboratory equipment. This technical breakthrough, which had eluded civilian researchers for years, substantially extends our capacity to detect and confirm marijuana use. We are also continuing to examine portable urine testing kits which can be used for screening in the field.

In 1979, DoD directed the Services to procure and deploy several kits and to evaluate the entire concept of portable drug testing. These evaluations were completed in February 1980. All Services found the concept of portable testing to be potentially useful, but found the current technology insufficient to meet their needs.

After completion of these evaluations, we decided it was again necessary to examine all the portable test kits on the market to determine which, if any, could satisfy the military Services' requirements for portable equipment. The Navy has requested to assume that responsibility. The Oakland Naval Regional Medical Center in California obtained specifications from potential suppliers, developed a test protocol, and submitted comments and recommendations to my office in July 1980. Three systems were recommended for technical testing. That testing began in November 1980 and was completed this Summer. All three systems have now been tested under varying conditions in the Oakland laboratory. All have some weaknesses, but all have some potential for use in the field. Effective 1 October 1981, a full scale field test of approved portable kits will begin.

A particularly promising development related to urine testing is the probability that we will be able to use urine testing results for disciplinary action. Court of Military Appeals decisions in U.S. vs. Armstrong, 9 M.J. 374 (CMA 1980) and U.S. vs. Lloyd 10 M.J. 172 (CMA 1981) leads us to believe we can write a policy which will provide more incentive to seek help for drug problems if needed, but will also enhance Commanders' authority to take disciplinary action against those caught as a result of urine testing. The policy has been drafted and is currently being coordinated. We also expect in the near future to begin to separate, with a General Discharge, drug abusers who refuse to cooperate with or who fail rehabilitation.

We anticipate that the combination of portable urine testing kits for screening in the field, a urine test which will detect marijuana, authority to discipline based upon urine testing results, and authority to separate those who cannot or will not be rehabilitated with a General Discharge will add substantially to our ability to deter and detect drug abuse.

With regard to another element of our deterrence and detection effort, an effective drug intelligence network involving DEA, State, the Defense Intelligence Agency, Services' investigating and intelligence agencies, and our office has been established. Sharing of information is routine. In fact, a member of my staff sits on the National Narcotics Intelligence Consumers Committee (NNICC) which develops the National Intelligence Estimate (NIE) each year. Unclassified military intelligence information is now included in the NIE.

DoD operated its own anti-smuggling and customs program, heavily employing sniffer dogs. Moreover, we have also provided extensive support, within the law, to Customs, DEA, Coast Guard and other Federal Agencies to help stop drug smuggling. For example, a Customs agent regularly rides on training flights of our Airborne Warning and Control System aircraft. We have loaned literally millions of dollars worth of aircraft, cameras, jeeps, trucks, night vision devices, intrusion detectors, sensors and other equipment to enforcement agencies. Customs has regularly operated out of Guantanamo Bay using Navy facilities. They currently operate out of several Air Force bases. Depending on what changes are made to "posse comitatus" as a result of pending legislation, we expect to do even more in this area.

Our internal drug law enforcement programs have been intensified, particularly in Europe. The Berlin Task Force, whose Chairmanship has now been turned over to the Governing Mayor of Berlin instead of our military commander, continues to function effectively. We launched paraphernalia suppression efforts last year, and are currently evaluating the effectiveness of those efforts. Use of sniffer dogs has been increased. On the whole, our deterrence and detection activities have been considerably improved during the last year, and they will continue to improve in the future. We are convinced that our prevention programs are doing much, and can do much more, to curb drug and alcohol abuse; deterrence and detection are critical components of that prevention effort.

EDUCATION AND TRAINING

Another crucial element of the prevention effort is our education and training program, which has recently been revised. This revised policy is promulgated in DoD Instruction 1010.5 which is attached for the record (Tab F). The instruction requires that specific learning objectives be accomplished for various target groups.

Classes for enlisted personnel emphasize both the positive and negative aspects of prevention. Desired behaviors and credible role models are stressed as well as healthy alternatives to abuse. Recruits are also made aware of the legal, health and career consequences of abuse. Officer and Warrent Officer candidates emphasize the duties and responsibilities of junior leaders in the prevention and control effort in addition to the consequences of personal substance abuse. The role of the junior officer in creating and maintaining military discipline, the causes, symptoms and prevalence of substance abuse and intervention and counseling techniques are stressed.

Continuing alcohol and drug abuse education is required at each Permanent Change of Station. For junior enlistees, classes center on the consequences of abuse, the local drug situation including local penalties for abuse and alternatives available at the local installations and neighboring community. Officers and non-commissioned officers are made aware of the command-unique elements of the substance abuse program and local prevalence rates and resources.

Officers and senior non-commissioned officers are also required to receive alcohol and drug abuse education during their professional military education which is tailored to their duties and responsibilities. Methods of deterrence and detection, coordination of law enforcement efforts, counseling and motivation skills and methods for monitoring the progress of identified abusers are stressed for junior officers. Middle and senior grade officers are made aware of the influence of their attitude about alcohol and drug abuse on subordinates, the reasons for and benefits derived from a vigorous prevention program, the need for command support for the substance abuse program, the Federal response to substance abuse, and intervention techniques for senior personnel with alcohol problems.

The instruction also mandates continuing alcohol and drug abuse education and training for health case professionals and program staff in those aspects of the program relevant to their duties and responsibilities. Department of Defense civilian employees are required to receive education on alcohol and drug abuse at the time of initial Department of Defense employment and periodically thereafter.

While all elements of the alcohol and drug abuse education program are important, what is accomplished during professional military education is critical. It is at that time that key commanders are made aware of the nature and scope of the alcohol and drug abuse problem and are given the opportunity to explore new, as well as, proven methods for reducing substance abuse in the military. This point has been emphasized in visits to each of the service schools for middle grade and senior grade officers. A second round of visits is planned for later this year.

Another illustration of this Department's commitment to improve and refine education and training is sponsorship of the Annual DoD World-Wide Conference. This year's 3d annual conference attracted 250 participants who represented the four military Services and the Defense agencies. The conference provided professional development seminars on treatment, education and civilian employee assistance as well as general sessions on marijuana, law enforcement, substance abuse and the family, and a command view of substance abuse in the military. We regret that invited members of Congress could not address the group as they have in the past. Serving as a concrete symbol of the Department's commitment, this conference not only provided for individual skill enhancement, it also provided a formal opportunity for multi-level interservice sharing of ideas, programs, and methodologies. The Department of Defense will host a similar conference in 1982.

A new media campaign for troops stationed abroad is planned for release later this year. The campaign features twelve radio and television alcohol and drug abuse prevention spot announcements developed under contract by the American Forces Radio and Television Service. This series of announcements is targeted for the eighteen to twenty-five year old service member. These spot announcements are supplemental to the audio-visual and printed material annually purchased through the American Forces Information Service in support of the Department's alcohol and drug abuse education effort.

REHABILITATION

Even with the finest education and deterrence programs, there will still be some individuals who will abuse alcohol and drugs and it is our job to rehabilitate and return to duty the maximum feasible number of those abusers. We oversee the largest alcohol and drug abuse rehabilitation network in the world with 56 residential facilities and 422 non-residential and referral centers. In fiscal year 1981 the DoD treated a total of 111,928 service members for alcohol and drug abuse, 21,405 of which were seen in residential facilities. A total of sixty-one million dollars was spent in FY 81 for all aspects of treatment and rehabilitation.

The Department of Defense has recently conducted a review of its residential, non-residential and referral facilities alcohol and drug abuse facilities. Using the results of this review and the guidelines set forth by the Joint Commission for the Accreditation of Hospitals, the Department of Defense published DoD Instruction 1010.6 on Rehabilitation and Referral which is attached for the record (Tab G).

This instruction establishes DoD policy for standards of care to be met by all DoD programs offering residential, non-residential and/or referral services, specifically, each category of service addresses: staff composition, educational preparation and professional growth and development, program entry and termination criteria, theraputic concepts, program components, family involvement and aftercare; and quality assurance criteria to ensure proper monitoring of care, record maintenance and case evaluations. Program evaluation to measure organizational needs, program goals, and proper allocation of resources is addressed.

Applicable to all DoD components, individual implementing documents shall be submitted to the Assistant Secretary of Defense for Health Affairs. Once the implementing documents have been sent to the field, on-site evaluations shall be conducted to determine compliance.

Recent evaluations of DoD alcohol and drug abuse rehabilitation facilities revealed trends in care provided and the status of continuing education for clinical staff. Dispelling an institutional assumption, all residential facilities also served at least one other military service's personnel with many serving two or more. Professional development was clearly evident in monthly in-service programs developed by individual facilities.

Family involvement in rehabilitation greatly increases the changes of a successful recovery. Most residential facilities have a family program. More work must be done in the non-residential and referral centers which treat the majority of military service member cases.

Future efforts in the area of rehabilitation will be directed to assessing compliance with DoD Instruction 1010.6, expanding family involvement in non-residential and referral centers, and expanding the number of multi-service facilities.

CIVILIAN PROGRAMS

During the past two years this office has been aggressively striving to enhance the services offered to our civilian employees based upon updated employee assistance program information and our assessment of civilian program needs. Public Law 91-616 (The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970) and Public Law 92-255 (The Drug Abuse

Office and Treatment Act of 1972) as amended by Public Law 92-282 charged the Department of Defense, as well as all other Federal Agencies, with responsibility for developing and maintaining ..."appropriate prevention, treatment, and rehabilitation programs and services..." for Federal civilian employees and to the extent feasible their families. These Public Laws, as well as the implementing instructions from the Office of Personnel Management (Chapter 792, subchapter 5 of the Federal Personnel Manual and FPM Supplement 792-2) have been fully implemented by the Department.

During FY 81, I, the Deputy Assistant Secretary of Defense for Drug and Alcohol Abuse personally made on-site visits to 75% of our Defense Agencies to convey my concern for the need of effective civilian alcohol and drug programs. The DoD has also within the past year, revised three basic policy documents which now include provisions for the operation of drug and alcohol programs for civilian employees. The Third Annual DoD Alcohol and Drug Abuse Conference was specifically designed to include a separate track with relevant information for our civilian programs.

Also, during the past year we developed and implemented the Pentagon Employee Referral Service (PERS) which services more than 14,000 civilian employees working in the Pentagon complex. This innovation currently represents "the state-of-the-art" for employee assistance programs operating within the Federal Government and is probably among the largest efforts to be found anywhere in the world. The PERS was planned during 1980 and began operation on 1 July 1981.

Comprehensive Care Corporation (Comp Care) was awarded the contract in May 1981 based on competitive bid. Comp Care is a health care management company specializing in the development, implementation, and management of alcoholism/drug treatment and psychiatric services. They are currently the largest private provider of hospital-based alcoholism treatment services in the United States.

The terms of this contract provide Department of Defense civilian employees with a high quality program at the Pentagon and serves as a reminder of the level of commitment to the military departments and Defense agencies. Secretary Weinberger has personally endorsed and fully supports the concept of providing employees the opportunity to resolve alcohol and drug problems and to return effective personnel to the work force. The specific components of the Pentagon Employee Referral Service (PERS) include:

- Training and Education. The contract provides for training of component alcohol and drug abuse coordinators, agency supervisors, executive level orientations, general audience awareness seminars, and programs for special populations.
- Marketing. The contractor is providing a marketing effort to enhance the image of the PERS and overcome the stigma and negative connotations oftentimes associated with an employee assistance program.
- Problem Identification. The contractor provides three trained counselors supervised by a clinical psychologist who initiate intake and evaluation procedures. They make the determination of what level of assistance is most appropriate for each client.

- Referral. A major responsibility of the contractor is to advise employees of resources available in the community to assist them (employees) with their problem.
- Aftercare/Follow-up. For those clients who enter a treatment program PERS counselors assist in the transition period when they come back to work. Additionally, they collect information about the quality of care received at the facility to update their community referral register.
- Program Evaluation. The contractor is assisting in the development of a program evaluation instrument with which DoD will assess the quantity and quality of this effort.
- Reporting System. The contractor provides a monthly report to program coordinators which provides them with data necessary to complete OPM reporting requirements.

In addition to the establishment of the PERS, we have witnessed a substantial improvement in the quality of civilian employee alcohol and drug abuse programs within the past two years. We expect even more success by expanding our current knowledge and raising the level of training of supervisors and program coordinators. We have shown that these programs work and are striving for an even more effective effort throughout the Department.

SUBSTANCE ABUSE RESEARCH

Looking to the future, as we continue striving to improve our means of identification of abusers and assessment of consequences, the Department of Defense maintains a keen interest in the area of research. Studies conducted during the past three years on the effects of substance abuse on individual and unit performance have yielded nominal results for several reasons: (1) competing priorities within a constrained R&D budget, (2) the complex nature of substance abuse problems in relation to measures of unit effectiveness and combat readiness, and (3) the "state-of-the-art" of research methods for shedding light on these issues.

Understanding the difficulties of launching and sustaining a comprehensive substance abuse research program requires a brief review of the events which have affected this research within DoD during the past five years.

In FY 1976 the House Appropriations Committee deleted all funds for DoD medical research on substance abuse, except in those instances where the subject of investigation is truly militarily unique. Although sound in theory, this guidance substantially decreased the priority for this research and led to a dismantling of substance abuse research programs and resources in the services. It also created a dependency on the National Institute of Drug Abuse (NIDA) and the National Institute for Alcohol Abuse and Alcoholism (NIAA) to address DoD research needs in areas such as individual performance, treatment evaluation and prevention. Unfortunately, neither of these agencies received additional resources to meet these requirements within the context of their charters and priorities. The DoD substance abuse research program was dissolved, in effect, and coordination with these Federal research agencies was limited to information sharing and participation on various committees and advisory councils.

In July 1978, the DEPSECDEF announced a twelve-point program to revitalize and improve the DoD substance abuse prevention program. One of the initiatives was the conduct of research concerning the impact of substance abuse on military readiness. The Army, which had some research expertise related to this subject in the Division of Neuropsychiatry, Walter Reed Army Institute for Research (WRAIR), was subsequently designated as the "DoD Executive Agent" for this initiative. However, no additional funds and manpower were available within a highly constrained R&D budget.

WRAIR was tasked to develop a comprehensive plan for conducting research on substance abuse effects on individual and unit performance. The Army Medical R&D Command internally reprogrammed funds to support the effort at a core level of about $500-$600K per year within the Military Psychiatry Research Budget. An $8 million, five-year research plan was drafted but was clearly unsupportable by DoD. So the Army was relegated to pursuing a limited effort within existing resources.

In FY 1980 the HAC again reduced funding for Military Psychiatry Research which led to a 50% cut for substance abuse research -- from $500-$600K to about $300K. Further budget reductions were sustained in FY 1981 which now limits substance abuse research to the use of "in house" expertise. The recently increased priority for chemical defense research, which draws on this same group of researchers, has also constrained DoD's ability to create and support any consistent substance abuse research program.

In this resource starved environment, the Army has been able to accomplish a few projects. The first involved a comprehensive review of scientific literature on drug and alcohol effects on individual performance. The project was concluded in December 1979 with the recommendation that further research in this area would be costly and of questionable value. Isolating the effects of different substances on the performance of discrete tasks in various military occupational specialties without the use of human subjects was impossible. There is also no laboratory technique for efficiently simulating a wide range of tasks from which valid and generalized findings can be made.

Research on substance abuse effects on combat readiness has proceeded on two tracks. A computer simulation analysis of hypothetical combat performance degradation was completed in April 1980. This abstract analysis, which assumed varying levels of abuse for personnel less than 25 years old in a "short war" scenario, indicated no serious degradation of combat capabilities except for the fire direction elements of artillery units. Unit force structures at company levels in the Army appear to be sufficiently flexible to permit reconstituting combat capabilities after sustaining drug or alcohol abuse and other combat casualties as high as 30 percent. A major limitation of the study is that it does not include an analysis of the human or sociological dynamics of substance abuse and troops in combat.

The second thrust of this research is a 41-week project to examine the effects of drug and alcohol abuse on the cohesion of tank crews. This project was started in March 1981 in USAREUR and data collection was complete in May. Data analysis is in progress and preliminary results are expected later this year. The project is designed to produce a practical methodology for assessing small group cohesion and relating patterns of substance abuse to cohesion and group performance.

A related project, which is separately sponsored by the U.S. Army Institute for the Behavioral and Social Sciences, is designed to evaluate the relationships between unit command climate and combat readiness measures. The project involves four waves of data which were collected in 55 battalions between May 1978 and November 1979. Interim results indicate that substance abuse is one of 21 measures consistently used by senior commanders to assess unit effectiveness, and that the subjective judgment of these commanders is consistently the best source for evaluating unit readiness. To date, surveys and interviews with commanders identify substance abuse as a problem but not to the extent that it affects unit combat readiness. The scientific correlation of drug abuse with quantitative and qualitative measures of command climate and readiness cannot be ascertained from this single project since it was designed to focus on the broader aspects of command climate.

Recently the Armed Forces Institute of Pathology developed a method for confirming the presence of cannabis products in the

the urine using gas chromatography. Normally, urine samples in the urinalysis laboratories are screened by radioimmunoassay technology for various drugs. Thereafter, the urine samples found positive for a drug have the presence of that drug confirmed by another technology, in this case by gas chromatography. Only then is the urine sample reported out of the laboratory as positive for the drug in question. Cannabis has been detectible by RIA for some time but the confirmatory process was lacking. AFIP has now cleared the way for full cannabis testing in the laboratory by developing a gas chromatography technology for confirming the positives detected by RIA.

In 1980 a project was jointly initiated with the National Institute of Alcohol Abuse and Alcoholism (NIAAA) to replicate research for developing a clinical technique for detecting alcoholism. The technique involves a special computer analysis of blood chemistry tests which are routinely administered with annual physicals or hospital admissions. Short, anonymous patient surveys are also used to supplement this analysis. This research, which is fully funded by NIAAA, is being conducted at the National Naval Medical Center and the Naval Drug Rehabilitation Center. The technique holds promise as an objective, economical means for detecting alcoholism. To date it has been 96% accurate in identifying both alcoholics and non-alcoholics in a VA hospital setting, except for people over age 65. However, the validity of this technique requires further research with the high risk, 18-24 year old population, which is prone to poly drug abuse. Preliminary results of this research are expected by December 1981 and an expanded field test is envisioned if the results are successful.

Recently the National Institute on Drug Abuse (NIDA) has expressed support for exploring the possibilities of research on the effects of drug abuse on individual and unit performance in the military. Coordination is in progress for NIDA to sponsor a conference on this subject with Service representatives in the October-November timeframe.

We have also considered enlisting the scientific expertise of the National Academy of Sciences to help examine the problem. Our preliminary contact with the Academy revealed that it would take about $400K for a 14 month level of effort to begin identifying the most relevant research methodologies for studying this complex problem. We have no estimate for how long thereafter it would take to conduct any of the recommended studies. The cost is prohibitive. This initiative was dropped.

In conclusion, the aforementioned initiatives indicate that the Department of Defense is committed to pursuing substance abuse research. The emphasis is on research projects which hold promise for yielding valid and useful results that can improve prevention programs, military readiness, and the health and welfare of military personnel, DoD employees and their family members.

PROGRAM EVALUATION

To assure the effectiveness of the various elements of the DoD alcohol and drug abuse prevention efforts, we are committed to a thorough evaluation of our programs.

We have made some initial progress, but have much left to do.

This year, we completed an evaluation of our drug and alcohol treatment program. This evaluation culminated in publication of a Department of Defense Instruction 1010.6, "Rehabilitation and Referral Services for Alcohol and Drug Abusers", which specifies staff, program, and quality assurance standards.

I mentioned earlier that we were working to suppress the availability of drug paraphernalia on and around our installations. We are presently evaluating the effectiveness of that effort, with results due this Winter.

A continual double-blind urine testing quality control evaluation has been instituted; with this we monitor laboratory effectiveness in identifying illicit drugs each month. We have also developed an evaluation scheme for comparing urine testing rates by region of the world with the drug threat for that region based on our Worldwide Survey. Additionally, in the drug testing area, we have completed a comprehensive laboratory evaluation of three portable urine testing kits. These kits will be further evaluated under field conditions beginning on 1 October 1981.

My office has been laboring to develop a comprehensive cost-benefit analysis for the entire alcohol and drug abuse prevention program. A model for evaluating the cost-benefit ratio has been developed, but we have been unable to accomplish the evaluation in-house. Accurate measurement of comprehensive costs and benefits is both difficult and expensive. The requisite manpower and skills are simply not available within the Department. We believe we need the information and are considering a contract effort next fiscal year.

One of the most important of our evaluation techniques is our field visit program. We have visited over 150 laboratories and programs in the last 18 months in order to evaluate program effectiveness. Visits have been to induction centers, training centers, drug detection laboratories, command headquarters, ships, bases, posts, hospitals, treatment centers and other locations. This direct observation by knowledgeable professionals remains one of our most effective evaluation tools.

SUMMARY

As I have said, the Department has looked at this problem squarely and honestly. We have done so at some risk. The highest purpose of the Armed Forces is to deter war. Deterrence must be both actual and perceived. If a potential enemy perceives weakness, deterrence is degraded. When we publicly illuminate a situation which degrades readiness we also degrade the perception of combat readiness. In addition, careless extrapolation of substance abuse statistics can and has resulted in the besmirching of the pride, self-confidence and demonstrated abilities of thousands of superb soldiers, sailors, marines and airmen serving in hundreds of tough, fighting-ready battlations, men-of-war and aircraft.

At the beginning of this statement much was made of the similarities between substance abuse prevalence among the youth of our society and the youth of our Armed Forces. Make no mistake, the Department of Defense from Secretary to Sergeant Major takes no comfort in that similarity. The Armed Forces serve in a high-technology, fast-paced, and often dangerous environment. The soldiers, sailors, marines and airmen who are not in full control of their mental and physical faculties, due to their own misconduct, are failing in their duty and are a threat to their comrades-in-arms. We have a comprehensive, multi-faceted program to reduce the abuse of alcohol and drugs. Our Commanders are by nature problem solvers and they have lots of problems to solve. Substance abuse is not always their first priority everyday, not only because they have complicated, difficult jobs, but because abusive behavior is not always a cause of ill discipline and poor performance, it is just as often a symptom of other problems embedded in the unit's mission and quality-of-life.

TABLE V-1

PREVALENCE OF NONMEDICAL DRUG USE AND ALCOHOL USE AMONG MILITARY PERSONNEL AND COMPARABLE CIVILIANS--AGES 18-25 (PERCENTAGE OF 18-25 YEAR OLD POPULATION)

TYPE	MILITARY (n= 8224)	COMPARABLE CIVILIANS[1] (n= 2022)
MARIJUANA/HASHISH		
PAST 30 DAYS	40	42
PAST 12 MONTHS	52	54
AMPHETAMINES OR OTHER UPPERS		
PAST 30 DAYS	10	4
PAST 12 MONTHS	21	12
COCAINE		
PAST 30 DAYS	7	10
PAST 12 MONTHS	18	23
HALLUCINOGENS		
PAST 30 DAYS	5	5
PAST 12 MONTHS	13	12
BARBITURATES OR OTHER DOWNERS		
PAST 30 DAYS	4	4
PAST 12 MONTHS	9	10
TRANQUILIZERS		
PAST 30 DAYS	3	3
PAST 12 MONTHS	9	12
HEROIN		
PAST 30 DAYS	1	1
PAST 12 MONTHS	3	1
ALCOHOL		
PAST 30 DAYS	84	82
PAST 12 MONTHS	93	90

[1] DATA STANDARDIZED WITH RESPECT TO SEX, AGE, MARITAL STATUS, AND EDUCATION. BASED ON SPECIAL TABULATIONS FROM THE 1979 NATIONAL SURVEY ON DRUG ABUSE.

HIGHLIGHTS FROM THE WORLDWIDE SURVEY OF NONMEDICAL DRUG USE AND ALCOHOL USE AMONG MILITARY PERSONNEL: 1980

by:

Marvin R. Burt, D.P.A.
Mark M. Biegel, M.A.

with the assistance of:

Yukiko Carnes, M.A.
Edward C. Farley, M.S.W.

The views and conclusions contained in this document are those of the authors and should not be interpreted as necessarily representing the official policies, either expressed or implied, of the Department of Defense or the U.S. Government.

Contract No. MDA903-79-C-0667

November 14, 1980

BURT ASSOCIATES, INCORPORATED
4340 East West Highway
Suite 506
Bethesda, Maryland 20014

TABLE OF CONTENTS

Page

Section 1: INTRODUCTION....................... 1

Section 2: NONMEDICAL DRUG USE-- PREVALENCE AND CONSEQUENCES AMONG MILITARY PERSONNEL......................... 2

Section 3: ALCOHOL USE--PREVALENCE AND CONSEQUENCES AMONG MILITARY PERSONNEL......................... 21

Section 4: COMPARISON OF DRUG AND ALCOHOL PREVALENCE AMONG MILITARY AND CIVILIAN POPULATIONS.............. 29

TECHNICAL NOTE................................ 31

Section 1: INTRODUCTION

This report is intended primarily to provide highlights of the results of a 1980 survey of nonmedical drug use and alcohol use among military personnel. Estimates are provided of the prevalence and consequences of nonmedical drug use and alcohol use among the active duty military population. The prevalence rates are compared with those obtained on a comparable civilian subpopulation. The findings are reported in statistical terms and can serve as an empirical basis for the formulation of policies and programs for the prevention and treatment of drug and alcohol abuse in the Military Services. More detailed findings are presented in the main report.[1]

The survey is focused on nonmedical use of nine types of drugs and on use of three types of alcoholic beverages. Samples of 81 installations, worldwide, and 19,582 active duty personnel at these installations were randomly selected. The selection was made from all personnel in pay grades El through 06 in each of the four Services. Ninety-three percent of the eligible sample completed the multiple choice format questionnaire in group sessions proctored solely by the study team of Burt Associates, Incorporated. Additional details on the sampling design population characteristics, number of respondents, and confidence intervals are summarized in the Technical Note at the end of this report.

In Section 2, summary findings are presented on current (past 30 days) and annual (past 12 months) nonmedical use of drugs and on the physical, social and work-related consequences of drug use. Similar information on alcohol use is highlighted in Section 3. The data are often presented for the total respondent group, by Service, and pay grade group.

Comparisons between prevalence data in this survey and the most recent survey of the civilian population are summarized in Section 4.

---

[1] Marvin R. Burt and Mark M. Biegel, Worldwide Survey of Nonmedical Drug Use and Alcohol Use Among Military Personnel: 1980 (Bethesda, Maryland: Burt Associates, Incorporated), 1980.

Section 2: NONMEDICAL DRUG USE - PREVALENCE AND CONSEQUENCES AMONG MILITARY PERSONNEL

"Nonmedical drug use" is defined, for the purpose of this survey, as the use of drugs for nonmedical purposes, that is, for highs, for thrills, to relax, to give insight, or for pleasure. The nonmedical use of drugs is common throughout broad segments of American society. Concern has been expressed about the extent to which military personnel engage in nonmedical drug use and the consequence of such use in terms of their individual well-being and their work performance. The survey results address these concerns.

Prevalence

The nine drug types used for prevalence estimates are listed below, together with verbatim examples from the questionnaire:

DRUG	EXAMPLE
Marijuana	"Pot," "Grass"
Hashish	"Hash"
PCP	"Angel Dust"
Other Hallucinogens	LSD, Mescaline, Peyote, STP, DOM, DMT, Psilocybin
Cocaine	"Coke," "Snow"
Amphetamines	Benzedrine, "Bennies," Methadrine, Dexedrine, "Speed"
Other Uppers	Preludin, Ritalin, Sandrex
Tranquilizers	Valium, Librium, Miltown
Barbiturates	Seconal (reds), Nembutal (yellows), Amytal (blues)
Other Downers	Quaalude (Sopors), Optimil, Doriden, Placidyl, Methaqualone
Heroin	"Smack," "Scag," "Horse"
Other Opiates	Morphine, Opium, Demerol, Codeine, Methadone

Table 1 shows that over one-fourth (27 percent) of the military personnel reported they had used some type of drug or drugs nonmedically in the past 30 days; over one-third (36 percent) reported such use within the past 12 months. The figures for marijuana or hashish use are much the same as those for "any drug use," indicating that nearly all users of nonmedical drugs used at least marijuana or hashish. None of the other eight drug types (listed in rank order of prevalence of use) approaches marijuana or hashish in popularity.

The percentages of military personnel reporting use of each drug weekly or more frequently than weekly during the past 30 days are shown in Table 2. Clearly, there are substantially fewer regular users (i.e., persons using weekly or more frequently) than occasional users. For example, while 36 percent reported use of marijuana or hashish during the past year, 27 percent reported use during the past 30 days and 19 percent reported use at least once a week during the past 30 days. This pattern generally holds for all the drug types (except that there is no difference between nonmedical use of barbiturates during the past 30 days and at least once a week). Thus, it can be concluded that the overwhelming majority of nonmedical drug use in the military is occasional or experimental in nature.

Prevalence rates vary by Service and region. It has not been established to what extent some or all of these variations are attributable to the different composition of the personnel in the four Services.[1]

Nonmedical drug use is limited primarily to personnel in the E1-E5 pay grade group (Tables 3 and 4), a phenomenon that may be attributable to the comparatively younger age of junior enlisted personnel. Patterns of use by drug and Service among E1-E5's are similar to those noted for the total respondent group.

Tables 5 through 13 depict the current prevalence for each of the nine drug types by Service, pay grade group, and geographical region. In general, current prevalence rates for each drug type are as high or higher in CONUS than in other regions.

---

[1] Drug prevalence correlates strongly with lower adult age, being unmarried, being male, and lower educational attainment. To the extent that a Service has a higher proportion of personnel with these characteristics, it can be expected to have a higher prevalence of nonmedical drug use.

TABLE 1

POPULATION USING EACH DRUG

(PERCENTAGE)

DRUG TYPE/ USE PERIOD	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
ANY DRUG USE					
PAST 30 DAYS	27	29	33	37	14
PAST 12 MONTHS	36	38	43	47	23
MARIJUANA/HASHISH					
PAST 30 DAYS	26	28	32	36	14
PAST 12 MONTHS	35	37	42	47	22
AMPHETAMINES OR OTHER UPPERS					
PAST 30 DAYS	6	6	10	8	3
PAST 12 MONTHS	13	12	19	19	6
COCAINE					
PAST 30 DAYS	4	4	7	8	1
PAST 12 MONTHS	11	10	17	19	5
HALLUCINOGENS (OTHER THAN PCP)					
PAST 30 DAYS	3	2	5	7	1
PAST 12 MONTHS	8	7	12	15	3
TRANQUILIZERS					
PAST 30 DAYS	2	2	3	2	1
PAST 12 MONTHS	6	5	9	7	2
BARBITURATES OR OTHER DOWNERS					
PAST 30 DAYS	2	3	3	3	1
PAST 12 MONTHS	6	6	8	9	3
OPIATES (OTHER THAN HEROIN)					
PAST 30 DAYS	1	2	2	2	+
PAST 12 MONTHS	4	4	5	6	1
PCP					
PAST 30 DAYS	1	1	1	3	+
PAST 12 MONTHS	4	4	5	10	1
HEROIN					
PAST 30 DAYS	1	1	1	+	+
PAST 12 MONTHS	2	3	1	1	+

+ LESS THAN HALF OF ONE PERCENT.

TABLE 2

FREQUENCY OF USING DRUG NONMEDICALLY AT LEAST ONCE A WEEK DURING THE PAST 30 DAYS--TOTAL DOD

(PERCENTAGE OF POPULATION)

DRUG TYPES	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
MARIJUANA/HASHISH	19	23	24	29	10
AMPHETAMINES OR OTHER UPPERS	3	3	5	4	1
COCAINE	2	1	3	3	+
BARBITURATES OR OTHER DOWNERS	1	2	1	1	+
HALLUCINOGENS (OTHER THAN PCP)	1	1	2	2	+
TRANQUILIZERS	1	1	1	2	1
OPIATES (OTHER THAN HEROIN)	+	1	1	1	+
PCP	+	+	+	1	+
HEROIN	+	+	+	+	+

+ LESS THAN HALF OF ONE PERCENT.

TABLE 3

POPULATION USING EACH DRUG--BY PAY GRADE GROUP

(PERCENTAGE)

DRUG TYPE/ USE PERIOD	TOTAL DOD	PAY GRADES				
		E1-E5	E6-E9	W1-W4	01-03	04-06
ANY DRUG USE						
PAST 30 DAYS	27	38	5	3	4	1
PAST 12 MONTHS	36	50	9	4	9	2
MARIJUANA/HASHISH						
PAST 30 DAYS	26	37	4	3	3	1
PAST 12 MONTHS	35	49	9	3	8	1
AMPHETAMINES OR OTHER UPPERS						
PAST 30 DAYS	6	9	1	0	+	+
PAST 12 MONTHS	13	19	2	0	1	+
COCAINE						
PAST 30 DAYS	4	7	+	0	+	0
PAST 12 MONTHS	11	17	1	2	+	+
HALLUCINOGENS (OTHER THAN PCP)						
PAST 30 DAYS	3	5	+	0	+	0
PAST 12 MONTHS	8	12	1	0	+	+
TRANQUILIZERS						
PAST 30 DAYS	2	3	+	0	+	0
PAST 12 MONTHS	6	8	1	+	1	+
BARBITURATES OR OTHER DOWNERS						
PAST 30 DAYS	2	3	+	0	+	0
PAST 12 MONTHS	6	8	1	0	1	0
OPIATES (OTHER THAN HEROIN)						
PAST 30 DAYS	1	2	+	0	+	0
PAST 12 MONTHS	4	5	+	0	+	+
PCP						
PAST 30 DAYS	1	1	+	0	0	0
PAST 12 MONTHS	4	6	+	0	+	0
HEROIN						
PAST 30 DAYS	1	1	+	0	0	0
PAST 12 MONTHS	2	2	+	0	0	+

+ LESS THAN HALF OF ONE PERCENT.

TABLE 4

POPULATION OF E1-E5'S USING EACH DRUG BY SERVICE

(PERCENTAGE)

DRUG TYPE/ USE PERIOD	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
ANY DRUG USE					
PAST 30 DAYS	38	41	48	48	21
PAST 12 MONTHS	50	53	59	61	33
MARIJUANA/HASHISH					
PAST 30 DAYS	37	40	47	47	20
PAST 12 MONTHS	49	52	58	60	32
AMPHETAMINES OR OTHER UPPERS					
PAST 30 DAYS	9	8	15	10	4
PAST 12 MONTHS	19	17	28	25	9
COCAINE					
PAST 30 DAYS	7	6	11	10	2
PAST 12 MONTHS	17	15	25	26	8
HALLUCINOGENS (OTHER THAN PCP)					
PAST 30 DAYS	5	3	7	10	2
PAST 12 MONTHS	12	10	18	21	5
TRANQUILIZERS					
PAST 30 DAYS	3	3	4	3	1
PAST 12 MONTHS	8	8	13	9	3
BARBITURATES OR OTHER DOWNERS					
PAST 30 DAYS	3	4	5	4	1
PAST 12 MONTHS	8	8	12	11	4
OPIATES (OTHER THAN HEROIN)					
PAST 30 DAYS	2	2	2	2	1
PAST 12 MONTHS	5	6	7	7	2
PCP					
PAST 30 DAYS	1	2	2	4	+
PAST 12 MONTHS	6	6	7	13	1
HEROIN					
PAST 30 DAYS	1	2	1	+	+
PAST 12 MONTHS	2	4	2	1	1

+ LESS THAN HALF OF ONE PERCENT.

TABLE 5

POPULATION USING MARIJUANA/HASHISH DURING PAST 30 DAYS (PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	27	29	34	39	14
E1-E5	39	41	48	51	21
E6-E9	5	6	6	5	3
01-03	3	5	2	6	2
04-06	1	0	0	0	1
EUROPE					
TOTAL	23	28	18	*	13
E1-E5	33	39	27	*	20
E6-E9	2	3	3	*	1
01-03	3	6	0	*	0
04-06	0	-	0	*	0
PACIFIC					
TOTAL	21	20	24	28	14
E1-E5	32	36	42	36	19
E6-E9	4	3	5	5	3
01-03	4	5	6	-	4
04-06	2	0	-	-	4
OTHER LOCATIONS					
TOTAL	22	29	21	*	13
E1-E5	32	38	33	*	19
E6-E9	4	8	3	*	0
01-03	4	-	-	*	-
04-06	0	-	-	*	-
TOTAL WORLDWIDE					
TOTAL	26	28	32	36	14
E1-E5	37	40	47	47	20
E6-E9	4	5	6	5	2
W1-W4	3	5	0	-	*
01-03	3	5	2	5	2
04-06	1	0	0	2	1

- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 6

POPULATION USING PCP
DURING PAST 30 DAYS
(PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	1	1	1	3	+
E1-E5	2	2	2	4	+
E6-E9	+	+	+	0	0
01-03	0	0	0	0	0
04-06	0	0	0	0	0
EUROPE					
TOTAL	1	1	+	*	+
E1-E5	1	1	+	*	+
E6-E9	0	0	0	*	0
01-03	0	0	0	*	0
04-06	0	-	0	*	0
PACIFIC					
TOTAL	1	1	1	1	0
E1-E5	1	1	1	2	0
E6-E9	0	0	0	0	0
01-03	0	0	0	-	0
04-06	0	0	-	-	0
OTHER LOCATIONS					
TOTAL	+	+	0	*	0
E1-E5	0	0	0	*	0
E6-E9	+	1	0	*	0
01-03	0	-	-	*	-
04-06	0	-	-	*	-
TOTAL WORLDWIDE					
TOTAL	1	1	1	3	+
E1-E5	1	2	2	4	+
E6-E9	+	+	+	0	0
W1-W4	0	0	0	-	*
01-03	0	0	0	0	0
04-06	0	0	0	0	0

+ LESS THAN HALF OF ONE PERCENT.
- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 7

POPULATION USING HALLUCINOGENS (OTHER THAN PCP) DURING PAST 30 DAYS (PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	4	2	6	8	1
E1-E5	5	4	8	11	2
E6-E9	+	0	1	0	0
O1-O3	+	0	0	1	0
O4-O6	0	0	0	0	0
EUROPE					
TOTAL	2	2	+	*	1
E1-E5	2	3	+	*	1
E6-E9	0	0	0	*	0
O1-O3	0	0	0	*	0
O4-O6	0	-	0	*	0
PACIFIC					
TOTAL	2	2	2	5	1
E1-E5	4	3	5	7	1
E6-E9	+	0	0	1	0
O1-O3	+	0	1	-	0
O4-O6	0	0	-	-	0
OTHER LOCATIONS					
TOTAL	1	3	1	*	0
E1-E5	2	4	1	*	0
E6-E9	0	0	0	*	0
O1-O3	0	-	-	*	-
O4-O6	0	-	-	*	-
TOTAL WORLDWIDE					
TOTAL	3	2	5	7	1
E1-E5	5	3	7	10	2
E6-E9	+	0	1	+	0
W1-W4	0	0	0	-	*
O1-O3	+	0	+	1	0
O4-O6	0	0	0	0	0

+ LESS THAN HALF OF ONE PERCENT.
- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 8

POPULATION USING COCAINE DURING PAST 30 DAYS (PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	5	4	8	8	1
E1-E5	7	6	11	11	2
E6-E9	+	+	1	0	0
01-03	+	0	+	1	0
04-06	0	0	0	0	0
EUROPE					
TOTAL	3	4	+	*	2
E1-E5	4	5	1	*	2
E6-E9	+	+	0	*	0
01-03	0	0	0	*	0
04-06	0	-	0	*	0
PACIFIC					
TOTAL	4	3	6	6	+
E1-E5	6	5	10	8	+
E6-E9	1	1	1	0	1
01-03	0	0	0	-	0
04-06	0	0	-	-	0
OTHER LOCATIONS					
TOTAL	4	6	2	*	2
E1-E5	6	8	4	*	3
E6-E9	+	1	0	*	0
01-03	0	-	-	*	-
04-06	0	-	-	*	-
TOTAL WORLDWIDE					
TOTAL	4	4	7	8	1
E1-E5	7	6	11	10	2
E6-E9	+	+	1	0	+
W1-W4	0	0	0	-	*
01-03	+	0	+	1	0
04-06	0	0	0	0	0

+ LESS THAN HALF OF ONE PERCENT.
- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 9

POPULATION USING AMPHETAMINES OR OTHER UPPERS DURING PAST 30 DAYS (PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	7	6	12	9	3
E1-E5	10	8	17	11	4
E6-E9	1	1	1	1	1
O1-O3	0	0	0	0	0
O4-O6	0	0	0	0	0
EUROPE					
TOTAL	5	6	3	•	2
E1-E5	7	9	5	•	3
E6-E9	1	1	0	•	0
O1-O3	+	0	3	•	0
O4-O6	0	-	0	•	0
PACIFIC					
TOTAL	4	3	4	4	3
E1-E5	6	6	7	6	4
E6-E9	+	0	0	1	1
O1-O3	1	2	1	-	1
O4-O6	+	0	-	-	2
OTHER LOCATIONS					
TOTAL	4	6	4	•	2
E1-E5	6	7	7	•	2
E6-E9	+	1	0	•	0
O1-O3	0	-	-	•	-
O4-O6	0	-	-	•	-
TOTAL WORLDWIDE					
TOTAL	6	6	10	8	3
E1-E5	9	8	15	10	4
E6-E9	1	1	1	1	1
W1-W4	0	0	0	-	•
O1-O3	+	+	+	0	+
O4-O6	+	0	0	0	+

+ LESS THAN HALF OF ONE PERCENT.
- LESS THAN 30 RESPONDENTS.
• NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 10

POPULATION USING TRANQUILIZERS DURING PAST 30 DAYS (PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	2	2	3	2	1
E1-E5	3	3	4	3	1
E6-E9	1	+	2	0	0
01-03	+	+	0	0	0
04-06	0	0	0	0	0
EUROPE					
TOTAL	2	3	3	*	1
E1-E5	3	4	5	*	2
E6-E9	+	0	0	*	1
01-03	0	0	0	*	0
04-06	+	-	0	*	1
PACIFIC					
TOTAL	2	2	2	3	1
E1-E5	3	4	4	3	1
E6-E9	+	0	0	1	0
01-03	0	0	0	-	0
04-06	0	0	-	-	0
OTHER LOCATIONS					
TOTAL	2	3	3	*	0
E1-E5	3	4	4	*	0
E6-E9	1	2	0	*	0
01-03	3	-	-	*	-
04-06	0	-	-	*	-
TOTAL WORLDWIDE					
TOTAL	2	2	3	2	1
E1-E5	3	3	4	3	1
E6-E9	+	+	1	+	+
W1-W4	0	0	0	-	*
01-03	+	+	+	0	0
04-06	0	0	0	0	0

+ LESS THAN HALF OF ONE PERCENT.
- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 11

POPULATION USING BARBITURATES OR OTHER DOWNERS DURING PAST 30 DAYS (PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	2	2	3	3	1
E1-E5	3	3	5	4	1
E6-E9	+	0	1	0	0
01-03	1	1	0	1	0
04-06	0	0	0	0	0
EUROPE					
TOTAL	2	3	2	•	1
E1-E5	3	4	2	•	1
E6-E9	0	0	0	•	0
01-03	0	0	0	•	0
04-06	0	-	0	•	0
PACIFIC					
TOTAL	2	2	2	3	1
E1-E5	3	4	4	4	1
E6-E9	0	0	0	0	0
01-03	0	0	0	-	0
04-06	0	0	-	-	0
OTHER LOCATIONS					
TOTAL	2	2	3	•	1
E1-E5	3	3	6	•	1
E6-E9	0	0	0	•	0
01-03	0	-	-	•	-
04-06	0	-	-	•	-
TOTAL WORLDWIDE					
TOTAL	2	3	3	3	1
E1-E5	3	4	5	4	1
E6-E9	+	0	1	0	0
W1-W4	0	0	0	-	•
01-03	+	1	0	1	0
04-06	0	0	0	0	0

+ LESS THAN HALF OF ONE PERCENT.
- LESS THAN 30 RESPONDENTS.
• NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 12

POPULATION USING HEROIN DURING PAST 30 DAYS (PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	1	1	1	+	+
E1-E5	1	1	1	+	+
E6-E9	+	0	+	0	0
01-03	0	0	0	0	0
04-06	0	0	0	0	0
EUROPE					
TOTAL	2	3	0	*	1
E1-E5	3	4	0	*	1
E6-E9	0	0	0	*	0
01-03	0	0	0	*	0
04-06	0	-	0	*	0
PACIFIC					
TOTAL	+	1	1	+	+
E1-E5	1	1	1	+	+
E6-E9	0	0	0	0	0
01-03	0	0	0	-	0
04-06	0	0	-	-	0
OTHER LOCATIONS					
TOTAL	+	0	0	*	+
E1-E5	+	0	0	*	+
E6-E9	0	0	0	*	0
01-03	0	-	-	*	-
04-06	0	-	-	*	-
TOTAL WORLDWIDE					
TOTAL	1	1	1	+	+
E1-E5	1	2	1	+	+
E6-E9	+	0	+	0	0
W1-W4	0	0	0	-	*
01-03	0	0	0	0	0
04-06	0	0	0	0	0

+ LESS THAN HALF OF ONE PERCENT.
- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

TABLE 13

POPULATION USING OPIATES (OTHER THAN HEROIN) DURING PAST 30 DAYS (PERCENTAGE)

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	1	1	2	2	+
E1-E5	2	2	2	2	1
E6-E9	+	+	+	+	0
01-03	+	1	0	1	0
04-06	0	0	0	0	0
EUROPE					
TOTAL	2	2	1	•	+
E1-E5	2	3	2	•	1
E6-E9	1	2	0	•	0
01-03	0	0	0	•	0
04-06	0	-	0	•	0
PACIFIC					
TOTAL	1	2	2	2	1
E1-E5	2	3	3	2	1
E6-E9	0	0	0	0	0
01-03	+	1	0	-	0
04-06	0	0	-	-	0
OTHER LOCATIONS					
TOTAL	1	1	+	•	+
E1-E5	1	1	1	•	+
E6-E9	0	0	0	•	0
01-03	0	-	-	•	-
04-06	0	-	-	•	-
TOTAL WORLDWIDE					
TOTAL	1	2	2	2	+
E1-E5	2	2	2	2	1
E6-E9	+	1	+	+	0
W1-W4	0	0	0	-	•
01-03	+	1	0	1	0
04-06	0	0	0	0	0

+ LESS THAN HALF OF ONE PERCENT.
- LESS THAN 30 RESPONDENTS.
• NOT APPLICABLE.

NOTE: REGIONAL TOTALS INCLUDE W1-W4'S.

Drug Dependence

For the purpose of this analysis, a person is defined as having been physiologically drug dependent during the past 12 months if he or she falls in one or more of the following categories:

1. Used one of the following drugs nonmedically at least five times per week during the past 30 days: barbiturates/other downers, heroin, or other opiates.
2. Experienced sickness (i.e., withdrawal symptoms) because use of addictive drugs was stopped; symptoms include: "runny nose or eyes," "flushed or sweaty," "chills," "nausea or vomiting," "stomach cramps," "diarrhea," "muscle pains," etc.
3. Was detoxified because of drug use.

For the purpose of this analysis, a person is classified as psychologically drug dependent who experiences sickness (i.e., withdrawal symptoms) because he or she stopped use of one or more non-addictive drugs; the symptoms are the same as defined earlier for physiological addiction.

From the results obtained, it is estimated that 3 percent of DOD junior enlisted personnel were physiologically drug dependent and that a total of 4 percent were physiologically or psychologically drug dependent at some time during the preceding 12 months. The percentage of E1-E5's who were drug dependent is depicted in Table 14.

TABLE 14

DRUG DEPENDENCE

(PERCENTAGE OF E1-E5 POPULATION)

TYPE OF DEPENDENCE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
PHYSIOLOGICAL	3	4	3	4	1
PHYSIOLOGICAL AND/OR PSYCHOLOGICAL	4	5	4	5	1

Consequences of Drug Use

The respondents were asked to indicate whether each of two consequences of nonmedical drug use had occurred during the past 12 months. Table 15 shows that 19 percent of the junior enlisted respondents reported suffering at least one of the consequences during the preceding 12 months.

TABLE 15

SELECTED CONSEQUENCES OF DRUG USE
(PERCENTAGE OF E1-E5 POPULATION)

CONSEQUENCE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
USED MORE DRUGS THAN PLANNED	10	9	13	14	6
HIGH MORE THAN 1 DAY AT A TIME	17	16	22	24	9
TOTAL WITH EITHER OF THE 2 CONSEQUENCES	19	18	25	27	11

The respondents were also asked to indicate whether each of 15 physical, social or work consequences had occurred because of their use of drugs during the past 12 months. Ten percent of the junior enlisted personnel reported suffering at least one of the 15 consequences during that period (Table 16).

Junior enlisted personnel who reported one or more of the 17 consequences[1] experienced them a median of three times.[2]

---

[1] This analysis combines both groups of consequences.

[2] A person experiencing consequences (say) three times could have experienced one consequence three times, three different consequences one time each, or another combination.

TABLE 16

SPECIFIC CONSEQUENCES OF DRUG USE DURING PAST 12 MONTHS

(PERCENTAGE OF E1-E5 POPULATION)

CONSEQUENCES	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
ILLNESS KEPT FROM DUTY 1 WEEK OR LONGER	2	3	1	2	+
DIDN'T GET PROMOTED	3	4	3	5	1
GOT LOWER SCORE ON EFFICIENCY OR PERFORMANCE REPORT	3	3	3	5	1
RECEIVED JUDICIAL OR ARTICLE 15 PUNISHMENT	4	5	4	5	2
ARRESTED FOR DRIVING AFTER USING DRUGS	1	2	1	2	1
ARRESTED FOR NON-DRIVING DRUG INCIDENT	4	4	4	6	2
INCARCERATED DUE TO DRUG USE	2	1	2	3	1
HURT IN ACCIDENT CONNECTED WITH DRUG USE	2	2	2	2	+
DRUG USE CAUSED ACCIDENT WHERE OTHERS HURT OR PROPERTY DAMAGED	1	1	2	2	1
SPOUSE THREATENED TO LEAVE	2	2	2	2	1
HIT SPOUSE OR CHILDREN	1	1	1	1	+
SPOUSE LEFT	1	1	1	1	+
ENTERED REHABILITATION OR TREATMENT PROGRAM	2	2	1	2	2
ATTENDED TRAINING OR EDUCATION PROGRAM	2	3	1	3	1
DETOXIFIED	1	1	1	1	+
TOTAL WITH ANY CONSEQUENCES[a]	10	11	13	15	5

[a] PERCENTAGE OF POPULATION REPORTING AT LEAST ONE OF THE CONSEQUENCES DURING THE PAST 12 MONTHS.

+ LESS THAN ONE-HALF OF ONE PERCENT.

Work Impairment

Turning now to a more specific focus on work impairment because of drug use, four types of work impairment are considered: (1) "lowered performance," (2) "late for work or left early,: (3) "did not come to work," and (4) "high while working."

The type of work impairment most frequently reported by junior enlisted personnel was "high while working" (19 percent); nearly one-half of the E1-E5 respondents indicating this had occurred reported experiencing this on 40 or more days during the preceding 12 months. Substantially lower proportions of E1-E5 respondents reported other work impairments, as shown in Table 17, and nearly all of them also reported being "high while working."

TABLE 17

WORK IMPAIRMENT BECAUSE OF DRUG USE
(PERCENTAGE OF E1-E5 POPULATION)

TYPE OF IMPAIRMENT	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
LOWERED PERFORMANCE	10	12	15	13	3
LATE FOR WORK/LEFT EARLY	6	8	8	8	2
DID NOT COME TO WORK	4	6	4	5	1
HIGH WHILE WORKING	19	21	26	25	8
TOTAL WITH ANY IMPAIRMENT	21	22	28	28	9

Section 3: ALCOHOL USE--PREVALENCE AND CONSEQUENCES AMONG MILITARY PERSONNEL

Prevalence of Alcohol Use

The percentage of the population that drank any alcohol during the past 30 days is depicted in Table 18.

TABLE 18

POPULATION USING ALCOHOL DURING PAST 30 DAYS
(PERCENTAGE)

PAY GRADE GROUP	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
TOTAL WORLDWIDE	83	80	86	86	82
E1-E5	83	81	88	86	82
E6-E9	77	75	78	83	78
W1-W4	76	76	80	-	*
O1-O3	83	80	88	91	82
O4-O6	91	92	94	84	90

- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

The principal point derived from these data is that most military personnel (83 percent) drank at least occasionally. In general, the highest prevalence of drinking any alcohol was recorded by senior officers, followed by junior officers and junior enlisted personnel, senior enlisted personnel and, warrant officers.

For all respondents worldwide, beer was the most commonly consumed beverage; it was drunk by 73 percent of all military personnel at least once within the past 30 days, and by about one-fourth (26 percent) at least three times a week. Hard liquor (including mixed drinks) was consumed by about one-half of the respondents (51 percent) within the past 30 days, but only 8 percent drank hard liquor as often as three times a week. Wine was the least frequently consumed beverage: only 35 percent of the military personnel had drunk any wine during the past 30 days, and only 4 percent had done so as often as three times a week.

Regional differences in drinking patterns are generally slight with the exception that consumption of wine is more prevalent in Europe than in other regions.

Heavy Drinking

We define "heavy drinking" as consumption of eight or more drinks in a single day. Table 19 shows that beer was the beverage that was heavily consumed by the most respondents. On a typical day in which beer was consumed, 8 percent drank eight or more "drinks" (a "drink" is one 12 ounce can, bottle or glass). Heavy drinking of wine was rarely reported, (a "drink" is one four ounce glass), but heavy drinking of hard liquor was reportedly nearly as common as heavy drinking of beer; 6 percent of all respondents reported consuming eight or more drinks of hard liquor on a typical drinking day during the past 30 days.

TABLE 19

QUANTITY CONSUMED ON A TYPICAL DRINKING DAY
DURING PAST 30 DAYS--WORLDWIDE TOTAL

(PERCENTAGE OF POPULATION)

BEVERAGE/ QUANTITY	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
BEER					
8-11 DRINKS	5	5	7	7	3
12 OR MORE DRINKS	3	3	5	4	1
WINE					
8-11 DRINKS	+	+	+	+	+
12 OR MORE DRINKS	1	1	1	1	1
HARD LIQUOR					
8-11 DRINKS	4	3	5	6	2
12 OR MORE DRINKS	2	2	3	2	1

+ LESS THAN HALF OF ONE PERCENT

Heavy drinking was reported almost exclusively by enlisted personnel. Twelve percent of E1-E5's and 4 percent of E6-E9's worldwide reported heavy drinking of beer; only 1 percent of each enlisted group reported heavy drinking of wine. The comparable figures for hard liquor were: E1-E5's, 8 percent;

E6-E9's, 3 percent. Only about 1 percent or less of each officer or warrant officer group worldwide reported heavy drinking of any beverage.

The preceding discussion was concerned with typical drinking during the past 30 days. Now we focus on the frequency that a person engaged in heavy drinking during the past 12 months. Table 20 shows that 21 percent of all respondents reported they had engaged in heavy drinking of beer at least one a week during the past 12 months; the comparable figures for wine and hard liquor were about 5 percent and 11 percent, respectively.

TABLE 20

HEAVY DRINKERS[1]--WORLDWIDE TOTAL

(PERCENTAGE OF POPULATION)

BEVERAGE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
BEER	21	22	25	28	13-14
WINE	5-6	8	5-6	7	3-4
HARD LIQUOR	11	12	14	13	7-8

[1] DEFINED AS A PERSON WHO DRANK EIGHT OR MORE 12 OUNCE CANS, GLASSES, OR BOTTLES OF BEER; EIGHT OR MORE FOUR OUNCE GLASSES OF WINE; OR EIGHT OR MORE DRINKS OF HARD LIQUOR IN A SINGLE DAY AT LEAST ONCE A MONTH DURING THE PAST 12 MONTHS.

The worldwide patterns of heavy drinking by pay grade group are as described previously for typical drinking, but the rates are higher. Heavy drinking was rarely reported by officers or warrant officers. Twenty-eight percent of E1-E5's and about 10 percent of E6-E9's reported heavy drinking of beer; the comparable figures for wine were 8 percent and about 1 percent of the E1-E5's and E6-E-9's, respectively. Fourteen percent of the E1-E5's and about 5 percent of E6-E9's reported heavy drinking of hard liquor.

Adverse Physiological Effects

There is compelling evidence that a person consuming a daily average of five ounces or more of ethanol during a year is at high risk of developing severe medical problems (e.g., cirrhotic or precirrhotic conditions).[1] Based on this threshold of presumptive harm, 7.9 percent of all DOD respondents are at high risk. Table 21 depicts the data by Service and pay grade group.

TABLE 21

POPULATION AT HIGH RISK FOR SEVERE MEDICAL PROBLEMS (PERCENTAGE)

PAY GRADE GROUP	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
TOTAL	7.9	9.2	9.9	10.1	3.6
E1-E5	10.9	12.2	13.9	12.9	5.3
E6-E9	3.1	4.9	2.7	2.6	1.3
W1-W4	0.2	0	1.0	-	*
O1-O3	0.7	1.5	0.1	0.9	0.4
O4-O6	0.6	0	0	2.4	1.0

- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.

Alcohol Dependence

For the purpose of this analysis, a person is defined as "alcohol dependent" who, during the preceding 12 month period, experienced one or more of the following symptoms during at least 48 of the 52 weeks: (1) tremors (shakes), (2) morning drinking, (3) impaired control, and (4) blackouts.

It is estimated that 7 percent of the military personnel worldwide were alcohol dependent during the preceding 12 months (Table 22). Alcohol dependency occurred predominantly among junior enlisted personnel (10 percent) and senior enlisted personnel (3 percent); it was rare among warrant officers and commissioned officers.

---

[1] Five ounces of ethanol is equivalent to approximately ten 12 ounce cans of beer, ten four ounce glasses of wine, or seven drinks of hard liquor (at 1.7 ounces of hard liquor per drink).

TABLE 22

ALCOHOL DEPENDENCE DURING PAST 12 MONTHS

(PERCENTAGE OF POPULATION)

PAY GRADE GROUP	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
TOTAL	7	8	9	11	4
E1-E5	10	11	12	14	5
E6-E9	3	3	5	4	2
W1-W4	+	0	0	-	*
O1-O3	1	1	+	5	+
O4-O6	+	0	1	1	1

+ LESS THAN HALF OF ONE PERCENT.
* NOT APPLICABLE.
- LESS THAN 30 RESPONDENTS.

The patterns shown are quite consistent with the heavy drinking patterns discussed previously. This is to be expected because of the substantial correlation between heavy drinking and alcohol dependency.

Consequences of Alcohol Use

The respondents were asked to indicate whether each of two consequences of alcohol use had occurred during the past 12 months. Table 23 shows that 23 percent of all respondents reported suffering at least one of the consequences.

TABLE 23

SELECTED CONSEQUENCES OF ALCOHOL USE DURING PAST 12 MONTHS

(PERCENTAGE OF POPULATION)

CONSEQUENCE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
BECAME DRUNK WITHOUT PLANNING TO	20	16	25	23	18
DRUNK MORE THAN ONE DAY AT A TIME	11	10	16	16	6
TOTAL WITH EITHER CONSEQUENCE	23	19	31	29	20

Junior enlisted personnel were the most likely to suffer at least one consequence, followed in turn by senior enlisted personnel, junior officers, senior officers, and warrant officers.

The respondents were also asked to indicate whether each of 15 physical, social, or work consequences had occurred because of their alcohol use during the past 12 months. Eleven percent reported suffering at least one of the 15 consequences during that period (Table 24).

Among those who reported that any of the 17 consequences[1] had occurred, they had occurred a median of three times.

Work Impairment

The percentage of the population reporting work impairment because of their alcohol use during the preceding 12 months is shown in Table 25. "Lowered performance" was the type of work impairment most frequently reported; it was reported by 22 percent of the total respondents and by 26 percent of E1-E5's and this occurred a median of two to three times. The figures on "total with any impairment" generally follow the patterns of heavy drinking discussed earlier. The patterns of impairment by pay grade group are in the following rank order by percentage suffering impairment: E1-E5's, E6-E9's, O1-O3's, O4-O6's, and W1-W4's.

---

[1] This analysis combines the two groups of consequences.

TABLE 24

CONSEQUENCES OF ALCOHOL USE DURING PAST 12 MONTHS--TOTAL DOD
(PERCENTAGE OF POPULATION)

CONSEQUENCE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
ILLNESS KEPT FROM DUTY 1 WEEK OR LONGER	2	2	2	2	1
DID NOT GET PROMOTED	2	2	1	3	1
GOT LOWER SCORE ON EFFICIENCY OR PERFORMANCE REPORT	2	2	3	4	1
RECEIVED JUDICIAL OR ARTICLE 15 PUNISHMENT	2	3	2	3	1
ARRESTED FOR DRIVING AFTER DRINKING	3	3	3	5	2
ARRESTED FOR NON DRIVING DRINKING INCIDENT	2	3	3	4	1
INCARCERATED DUE TO DRINKING	3	2	4	5	1
HURT IN ACCIDENT CONNECTED WITH DRINKING	2	2	4	4	1
DRINKING CAUSED ACCIDENT WHERE OTHERS HURT OR PROPERTY DAMAGED	2	2	3	3	1
SPOUSE THREATENED TO LEAVE	2	2	2	2	1
HIT SPOUSE OR CHILDREN	1	1	1	2	1
SPOUSE LEFT	1	1	+	1	+
ENTERED REHABILITATION OR TREATMENT PROGRAM	2	2	2	2	1
ATTENDED TRAINING OR EDUCATION PROGRAM	2	2	2	3	1
DETOXIFIED	1	1	1	1	+
TOTAL WITH ANY CONSEQUENCE 1/	11	11	14	17	6

1/ PERCENTAGE OF POPULATION WITH AT LEAST ONE OF THE CONSEQUENCES DURING THE PAST 12 MONTHS.

+ LESS THAN HALF OF ONE PERCENT.

TABLE 25

WORK IMPAIRMENT BECAUSE OF ALCOHOL USE DURING PAST 12 MONTHS

(PERCENTAGE OF POPULATION)

IMPAIRMENT/ PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
LOWERED PERFORMANCE					
TOTAL	22	19	30	29	17
E1-E5	26	23	34	32	19
E6-E9	17	13	22	22	14
W1-W4	9	4	12	-	*
O1-O3	15	12	28	20	10
O4-O6	10	7	8	14	14
LATE FOR WORK OR LEFT EARLY					
TOTAL	13	13	17	16	10
E1-E5	16	15	21	17	12
E6-E9	9	9	10	15	7
W1-W4	2	2	0	-	*
O1-O3	7	8	9	5	5
O4-O6	4	1	7	8	5
DID NOT COME TO WORK					
TOTAL	5	6	5	5	2
E1-E5	6	8	7	6	2
E6-E9	2	2	3	3	2
W1-W4	1	1	0	-	*
O1-O3	0	0	0	2	0
O4-O6	1	0	0	0	2
DRUNK/HIGH WHILE WORKING					
TOTAL	11	11	16	15	6
E1-E5	15	16	21	19	7
E6-E9	5	4	7	7	3
W1-W4	1	1	0	-	*
O1-O3	3	2	6	1	2
O4-O6	3	0	7	0	3
TOTAL WITH ANY IMPAIRMENT					
TOTAL	27	24	35	34	20
E1-E5	31	29	40	38	24
E6-E9	19	16	25	25	16
W1-W4	9	4	12	-	*
O1-O3	17	15	29	21	12
O4-O6	12	7	14	15	15

- LESS THAN 30 RESPONDENTS.
* NOT APPLICABLE.
+ LESS THAN HALF OF ONE PERCENT.

Section 4: COMPARISON OF DRUG AND ALCOHOL PREVALENCE AMONG MILITARY AND CIVILIAN POPULATIONS

This analysis is restricted to the subpopulation at highest risk for nonmedical drug use in both military and civilian populations: persons 18 through 25 years of age. The data have been standardized with respect to the variables that are most closely correlated with nonmedical drug use: sex, age, marital status, and education. Standardization with respect to these variables serves to provide prevalence rates that are not biased by the differences in occurrence of these characteristics in the two populations. The specific procedures employed to standardize the data and the limitations in the analysis are described in the main report.

Table 26 shows the prevalence of nonmedical drug use among military personnel and comparable civilians, ages 18 through 25. Prevalence of current nonmedical drug use for military personnel is slightly lower or equal to civilian use for all drug types analyzed, with the exception of amphetamines or other uppers. Prevalence of annual use is lower for military personnel than civilians with respect to four drug types and higher than civilians for three drug types. There is, thus, no general pattern of nonmedical drug use being more prevalent for military personnel than civilians.

Regarding alcohol use, slightly higher proportions of military personnel than civilians drank at all during the past 30 days and the past year.

TABLE 26

PREVALENCE OF NONMEDICAL DRUG USE AND ALCOHOL USE AMONG MILITARY PERSONNEL AND COMPARABLE CIVILIANS--AGES 18-25 (PERCENTAGE OF 18-25 YEAR OLD POPULATION)

TYPE	MILITARY (n= 8224)	COMPARABLE CIVILIANS[1] (n= 2022)
MARIJUANA/HASHISH		
PAST 30 DAYS	40	42
PAST 12 MONTHS	52	54
AMPHETAMINES OR OTHER UPPERS		
PAST 30 DAYS	10	4
PAST 12 MONTHS	21	12
COCAINE		
PAST 30 DAYS	7	10
PAST 12 MONTHS	18	23
HALLUCINOGENS		
PAST 30 DAYS	5	5
PAST 12 MONTHS	13	12
BARBITURATES OR OTHER DOWNERS		
PAST 30 DAYS	4	4
PAST 12 MONTHS	9	10
TRANQUILIZERS		
PAST 30 DAYS	3	3
PAST 12 MONTHS	9	12
HEROIN		
PAST 30 DAYS	1	1
PAST 12 MONTHS	3	1
ALCOHOL		
PAST 30 DAYS	84	82
PAST 12 MONTHS	93	90

[1] DATA STANDARDIZED WITH RESPECT TO SEX, AGE, MARITAL STATUS, AND EDUCATION. BASED ON SPECIAL TABULATIONS FROM THE 1979 NATIONAL SURVEY ON DRUG ABUSE.

TECHNICAL NOTE

This technical note contains a description of the sample design, the confidence limits, and the number of respondents.

Sample Design

The DOD stipulated that a sample be drawn of all active duty military personnel throughout the world from which reliable estimates of drug and alcohol use could be made with known degrees of error for each of the Military Services, for five pay grade groupings, and for three main geographical regions and "Other Locations." It was further stipulated that the response rate among sampled personnel be 80 percent or higher, without replacements.

Because of budgetary and time constraints, it was not possible to survey every servicemember in each of the more than 300 locations throughout the world. These considerations dictated a design that sampled both personnel and locations by probability means. A stratified multistage probability sample was subsequently developed and implemented. Both sites and personnel were randomly selected. Differential personnel sampling rates were used to obtain sufficient sample sizes in the various respondent subgroups. Sample weighting procedures were applied to put the complete respondent sample into balance; these are described in the main report.

The final sample size required for each Service by geographical region is shown in Table 27. The sample was composed of 19,582 military personnel stationed at 81 installations.[1] As shown in Table 28, the survey respondents were predominately male, white and between the ages of 18 through 25. As indicated also, the sample was very representative of all DOD personnel, worldwide, with respect to the characteristics shown. The population represented by the sample is depicted in Tables 29 and 30.

At each survey site, a random sample was drawn from the most current listing of all personnel assigned to the installation.[2] The random selection was made from all personnel

---

[1] An installation was composed of all permanent parent and tenant units at a base, post, camp, station or ships in a designated location.

[2] The detailed sample selection procedures were designed to accommodate unique Service personnel accounting systems and local capabilities to produce the random sample.

TABLE 27

SAMPLE ALLOCATION

REGION	NO. SITES	SAMPLE
ARMY	(19)	(6,239)
CONUS	8	3,026
EUROPE	4	1,320
PACIFIC	5	1,548
OTHER	2	345
NAVY	(30)	(5,202)
CONUS	17	3,202
EUROPE	5	600
PACIFIC	7	1,174
OTHER	1	226
MARINE CORPS	(10)	(2,861)
CONUS	7	1,917
PACIFIC	3	944
AIR FORCE	(22)	(5,280)
CONUS	11	2,464
EUROPE	5	1,066
PACIFIC	5	1,284
OTHER	1	466
TOTAL	(81)	(19,582)
CONUS	43	10,609
EUROPE	14	2,986
PACIFIC	20	4,950
OTHER	4	1,037

TABLE 28

DEMOGRAPHIC CHARACTERISTICS OF SURVEY RESPONDENTS AND ALL DOD MILITARY PERSONNEL

(PERCENTAGE OF POPULATION)

CHARACTERISTIC	TOTAL SURVEY	DOD ACTUAL[1]
SEX		
MALE	91	92
FEMALE	9	8
RACE/ETHNIC		
WHITE/CAUCASIAN	71	73
AFRO AMERICAN/BLACK	18	19
HISPANIC	5	4
ORIENTAL/ASIAN/PACIFIC ISLANDER	3	1
AMERICAN INDIAN/ALASKAN NATIVE	1	2
OTHER	2	1
MARITAL STATUS		
MARRIED	53	52
NOT MARRIED	47	48
AGE		
17 OR UNDER	1	1
18-25	55	56
26-29	15	14
30-34	13	13
35-39	10	10
40 OR OVER	6	6

---

[1] MARCH 1980: DEFENSE MANPOWER DATA CENTER.

TABLE 29

POPULATION REPRESENTED BY THE SAMPLE

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	1,393,269	454,158	416,283	128,951	393,878
E1-E5	924,659	304,537	282,565	95,412	242,146
E6-E9	251,356	77,221	85,085	18,951	70,099
W1-W4	14,498	9,066	3,091	2,341	*
O1-O3	126,085	39,207	28,121	8,243	50,514
O4-O6	76,671	24,127	17,421	4,004	31,119
EUROPE					
TOTAL	287,004	190,205	21,625	*	75,174
E1-E5	194,521	131,295	13,485	*	49,741
E6-E9	63,700	42,299	4,467	*	16,934
W1-W4	2,979	2,713	267	*	*
O1-O3	16,879	9,407	1,976	*	5,497
O4-O6	8,924	4,491	1,431	*	3,002
PACIFIC					
TOTAL	165,471	36,263	45,596	39,388	44,224
E1-E5	103,543	19,225	24,553	29,281	30,484
E6-E9	40,275	11,252	13,211	6,531	9,281
W1-W4	2,000	802	851	347	*
O1-O3	11,668	2,692	3,464	2,425	3,086
O4-O6	7,984	2,291	3,517	803	1,374
OTHER LOCATIONS					
TOTAL	44,023	18,388	14,892	*	10,744
E1-E5	29,170	13,159	8,667	*	7,344
E6-E9	9,595	3,093	4,250	*	2,251
W1-W4	625	352	273	*	*
O1-O3	2,881	1,160	911	*	810
O4-O6	1,753	624	790	*	339
TOTAL WORLDWIDE					
TOTAL	1,889,766	699,013	498,395	168,338	524,020
E1-E5	1,251,893	468,216	329,269	124,693	329,715
E6-E9	364,926	133,866	107,013	25,482	98,564
W1-W4	20,103	12,933	4,482	2,688	*
O1-O3	157,512	52,465	34,472	10,668	59,907
O4-O6	95,332	31,533	23,159	4,808	35,833

* NOT APPLICABLE.

TABLE 30

POPULATION OF E1-E5's REPRESENTED BY SAMPLE

GEOGRAPHICAL REGION	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	924,659	304,537	282,565	95,412	242,146
EAST	608,118	234,696	217,530	39,228	116,664
WEST	316,542	69,841	65,035	56,184	125,422
EUROPE					
TOTAL	194,521	131,295	13,485	•	49,741
GERMANY	155,380	131,295	•	•	24,085
ITALY	7,477	•	7,477	•	•
ENGLAND	14,282	•	653	•	13,629
SPAIN	17,382	•	5,355	•	12,028
PACIFIC					
TOTAL	103,543	19,225	24,553	29,281	30,484
HAWAII	29,426	5,628	10,135	10,477	3,186
JAPAN	40,576	3,590	5,994	18,805	12,187
KOREA	18,943	10,007	•	•	8,936
PHILIPPINES	10,170	•	3,995	•	6,175
GUAM	4,429	•	4,429	•	•
OTHER LOCATIONS					
TOTAL	29,170	13,159	8,667	•	7,344
PANAMA CANAL	5,976	5,976	•	•	•
ALASKA	14,527	7,183	•	•	7,344
GUANTANAMO BAY	8,667	•	8,667	•	•
TOTAL WORLDWIDE	1,251,893	468,216	329,269	124,693	329,715

• NOT APPLICABLE.

in pay grades E1 through O6 of the one designated Service permanently assigned to organizations included in the specified installation. The last two digits of the individual's Social Security Account Number were used as the device for random selection of the respondents. Not included in the population base from which a sample was drawn were those personnel in recruit or basic training and those personnel in units known or expected to be at sea or deployed away from the installation at the time of the questionnaire administration. Personnel selected for the sample could be excused from questionnaire administration only for the following authorized reasons:

- on leave from the parent organization
- on temporary duty away from the installation
- absent without leave
- assigned a permanent change of station
- separated from the Service

Absences for any other reason were designated as "no-shows."

It is well known that a survey based on samples of a population can only approximate the level of accuracy that would be obtained if it were possible for the entire population to participate in the survey. Because of this, there is a need to know the precision of the estimates from a particular sample survey. The 95 percent confidence limits for any percentage estimate reported in this volume are provided later in this Technical Note. These confidence limits are particularly important where estimates are given for subgroups of the population. The reader should be aware that those subgroups with relatively few cases will have relatively greater margins of error than those subgroups with a larger number of respondents. This notably includes subgroups of officers and warrant officers. Regional data on officers should be viewed with particular caution, because of the small number of respondents in those subgroups. The number of respondents in each subgroup is depicted in Tables 31 and 32.

Confidence Limits and Significance of Differences

An important issue in all prevalence surveys based on data obtained from samples of a population is the extent to which one can be confident that the prevalence estimates obtained accurately reflect the true prevalence for the entire population. That is, if every servicemember responded to the questionnaire, would the prevalence rate be substantially different from that obtained from the sample of personnel surveyed?

For any particular percentage given in the prevalence

TABLE 31

NUMBER OF RESPONDENTS

GEOGRAPHICAL REGION/PAY GRADE	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	8,286	2,345	2,802	1,194	1,945
E1-E5	5,475	1,545	1,927	873	1,130
E6-E9	1,717	527	635	188	367
W1-W4	74	35	23	16	*
O1-O3	624	165	152	67	240
O4-O6	396	73	65	50	208
EUROPE					
TOTAL	2,329	923	557	*	849
E1-E5	1,547	660	361	*	526
E6-E9	476	175	128	*	173
W1-W4	18	14	4	*	*
O1-O3	163	46	32	*	85
O4-O6	125	28	32	*	65
PACIFIC					
TOTAL	3,766	1,076	1,084	624	982
E1-E5	2,531	659	738	478	656
E6-E9	836	283	245	94	214
W1-W4	37	19	13	5	*
O1-O3	223	69	59	29	66
O4-O6	139	46	29	18	46
OTHER LOCATIONS					
TOTAL	887	279	228	*	380
E1-E5	601	195	135	*	271
E6-E9	202	65	69	*	68
W1-W4	6	3	3	*	*
O1-O3	47	10	10	*	27
O4-O6	31	6	11	*	14
TOTAL WORLDWIDE					
TOTAL	15,268	4,623	4,671	1,818	4,156
E1-E5	10,154	3,059	3,161	1,351	2,583
E6-E9	3,231	1,050	1,077	282	822
W1-W4	135	71	43	21	*
O1-O3	1,057	290	253	96	418
O4-O6	691	153	137	68	333

* NOT APPLICABLE.

TABLE 32

NUMBER OF E1-E5 RESPONDENTS

GEOGRAPHICAL REGION	TOTAL DOD	SERVICE			
		ARMY	NAVY	MARINE CORPS	AIR FORCE
CONUS					
TOTAL	5,475	1,545	1,927	873	1,130
EAST	3,612	1,236	1,379	492	505
WEST	1,863	309	548	381	625
EUROPE					
TOTAL	1,547	660	361	*	526
GERMANY	859	660	*	*	199
ITALY	181	*	181	*	*
ENGLAND	198	*	27	*	171
SPAIN	309	*	153	*	156
PACIFIC					
TOTAL	2,531	659	738	478	656
HAWAII	652	201	246	115	90
JAPAN	1,011	106	292	363	250
KOREA	545	352	*	*	193
PHILIPPINES	214	*	91	*	123
GUAM	109	*	109	*	*
OTHER LOCATIONS					
TOTAL	601	195	135	*	271
PANAMA CANAL	85	85	*	*	*
ALASKA	381	110	*	*	271
GUANTANAMO BAY	135	*	135	*	*
TOTAL WORLDWIDE	10,154	3,059	3,161	1,351	2,583

* NOT APPLICABLE.

data tables, we cannot know exactly how much error has resulted from sampling. However, reasonably good estimates can be made of the range within which the responses of the total population would fall. The estimation of confidence limits for the results of the survey is a complex statistical decision and procedure. The following formula has been used to determine asymmetric confidence limits at the 95% level of confidence for sample percentage estimates:

$$P_L = p' - 1.96 \left[P_L(1-p_L)/n\right]^{\frac{1}{2}} \quad (1.3)$$

$$P_U = p' + 1.96 \left[P_U(1-p_U)/n\right]^{\frac{1}{2}} \quad (1.3)$$

Where:

P_L = lower limit of the confidence interval

p' = the estimate based on the sample

n = the sample size

p_U= the upper limit of the confidence interval

Table 33 depicts the upper and lower confidence limits for sample estimates.

In comparing two sample estimates, it is important to determine whether the difference between the two estimates is statistically significant. That is, can the difference reasonably be attributable to sampling variations or is it "real." Table 34 displays, for various sample sizes, the minimum difference between two percentage estimates that would be required for the difference to be statistically significant at the .05 level of confidence. For example, if a percentage result is 20 percent for E1-E5's and 15 percent for E6-E9's and the respective sample sizes were 1,000 and 500, there would have to be a difference of at least 5.6 percent for it to be considered a real difference and not attributable to chance. Thus, for this example, the difference would not be statistically significant at the .05 level.

TABLE 33

CONFIDENCE LIMITS FOR SAMPLE ESTIMATES

	OBSERVED PERCENTAGE														
	1.0%		3.0%		5.0%		10.0%		20.0%		30.0%		40.0%		50.0%
	-	+	-	+	-	+	-	+	-	+	-	+	-	+	±
n= 100	0.9%	6.7%	2.3%	7.8%	3.3%	8.6%	5.4%	10.2%	8.3%	11.9%	10.2%	12.6%	11.5%	12.7%	12.4%
200	0.8%	3.8%	1.9%	4.8%	2.7%	5.5%	4.3%	6.7%	6.2%	8.1%	7.6%	8.7%	8.4%	9.0%	8.8%
300	0.7%	2.8%	1.7%	3.6%	2.4%	4.3%	3.6%	5.3%	5.2%	6.4%	6.2%	7.1%	7.0%	7.4%	7.3%
400	0.7%	2.2%	1.6%	3.0%	2.2%	3.5%	3.2%	4.5%	4.5%	5.5%	5.5%	6.1%	6.0%	6.3%	6.3%
500	0.6%	1.9%	1.5%	2.6%	2.0%	3.1%	3.0%	4.0%	4.2%	4.9%	5.0%	5.4%	5.4%	5.7%	5.6%
600	0.6%	1.7%	1.4%	2.3%	1.9%	3.0%	2.7%	3.5%	3.8%	4.5%	4.6%	5.0%	5.0%	5.2%	5.2%
700	0.6%	1.5%	1.2%	2.1%	1.8%	2.5%	2.5%	3.2%	3.5%	4.2%	4.3%	4.6%	4.5%	4.8%	4.8%
800	0.6%	1.4%	1.2%	2.0%	1.7%	2.3%	2.4%	3.0%	3.3%	3.8%	4.0%	4.3%	4.1%	4.5%	4.5%
900	0.5%	1.3%	1.1%	1.8%	1.6%	2.2%	2.3%	2.8%	3.2%	3.6%	3.7%	4.1%	4.1%	4.3%	4.3%
1000	0.5%	1.1%	1.1%	1.7%	1.5%	2.1%	2.2%	2.7%	3.0%	3.4%	3.5%	3.8%	3.8%	4.0%	4.1%
2000	0.4%	0.7%	0.8%	1.1%	1.1%	1.4%	1.6%	1.9%	2.2%	2.4%	2.6%	2.7%	2.8%	2.8%	2.8%
3000	0.4%	0.6%	0.7%	0.9%	0.9%	1.1%	1.4%	1.5%	1.8%	1.9%	2.1%	2.2%	2.3%	2.3%	2.3%
4000	0.3%	0.5%	0.6%	0.7%	0.8%	0.9%	1.1%	1.3%	1.6%	1.7%	1.8%	1.9%	2.0%	2.0%	2.0%
5000	0.3%	0.4%	0.5%	0.6%	0.7%	0.8%	1.0%	1.1%	1.4%	1.5%	1.7%	1.7%	1.8%	1.8%	1.8%
10000	0.2%	0.3%	0.4%	0.5%	0.5%	0.6%	0.7%	0.8%	1.0%	1.0%	1.2%	1.2%	1.2%	1.2%	1.3%
15000	0.2%	0.2%	0.3%	0.4%	0.4%	0.5%	0.6%	0.6%	0.8%	0.8%	0.9%	1.0%	1.0%	1.0%	1.0%
	+	-	+	-	+	-	+	-	+	-	+	-	+	-	±
	99.0%		97.0%		95.0%		90.0%		80.0%		70.0%		60.0%		50.0%
	OBSERVED PERCENTAGE														

TABLE 34

DIFFERENCES REQUIRED FOR SIGNIFICANCE ACCORDING TO SAMPLE SIZE

SIZE OF SAMPLES COMPARED	OBSERVED PERCENTAGE 10% or 90%	20% or 80%	25% or 75%	30% or 70%	35% or 65%	40% or 60%	50%
3300 and 3300	1.9%	2.5%	2.7%	2.9%	3.0%	3.1%	3.1%
3000	1.9%	2.6%	2.8%	2.9%	3.0%	3.1%	3.2%
2500	2.0%	2.7%	2.9%	3.0%	3.2%	3.3%	3.3%
2000	2.2%	2.9%	3.1%	3.3%	3.4%	3.5%	3.6%
1500	2.4%	3.2%	3.4%	3.6%	3.7%	3.8%	4.0%
1000	2.8%	3.6%	4.0%	4.3%	4.4%	4.5%	4.6%
500	3.6%	4.9%	5.3%	5.6%	5.8%	6.0%	6.1%
3000 and 3000	2.0%	2.6%	2.8%	3.0%	3.1%	3.2%	3.3%
2500	2.1%	2.8%	3.0%	3.1%	3.3%	3.4%	3.4%
2000	2.2%	2.9%	3.2%	3.3%	3.5%	3.6%	3.6%
1500	2.4%	3.2%	3.5%	3.7%	3.8%	4.0%	4.1%
1000	2.8%	3.7%	4.1%	4.3%	4.5%	4.6%	4.7%
500	3.7%	4.9%	5.3%	5.6%	5.8%	6.0%	6.1%
2500 and 2500	2.2%	2.9%	3.1%	3.3%	3.4%	3.5%	3.6%
2000	2.3%	3.0%	3.3%	3.5%	3.6%	3.7%	3.8%
1500	2.5%	3.3%	3.6%	3.8%	4.0%	4.1%	4.2%
1000	2.9%	3.8%	4.2%	4.4%	4.6%	4.7%	4.8%
500	3.7%	5.0%	5.4%	5.7%	5.9%	6.1%	6.2%
2000 and 2000	2.4%	3.2%	3.5%	3.7%	3.8%	4.0%	4.1%
1800	2.5%	3.3%	3.5%	3.7%	4.0%	4.1%	4.2%
1600	2.6%	3.4%	3.7%	4.0%	4.1%	4.2%	4.3%
1400	2.7%	3.5%	3.8%	4.1%	4.3%	4.4%	4.5%
1200	2.8%	3.7%	4.1%	4.3%	4.5%	4.6%	4.7%
1000	2.9%	4.0%	4.3%	4.5%	4.7%	4.8%	4.9%
800	3.2%	4.3%	4.6%	4.9%	5.1%	5.2%	5.3%
600	3.5%	4.8%	5.1%	5.4%	5.6%	5.8%	5.9%
400	4.2%	5.6%	6.0%	6.3%	6.7%	6.9%	7.0%
200	5.7%	7.6%	8.2%	8.6%	9.0%	9.3%	9.5%

(CONTINUED)

SIZE OF SAMPLES COMPARED	OBSERVED PERCENTAGE 10% or 90%	20% or 80%	25% or 75%	30% or 70%	35% or 65%	40% or 60%	50%
1000 and 1000	3.4%	4.6%	4.9%	5.2%	5.4%	5.6%	5.7%
900	3.5%	4.7%	5.1%	5.4%	5.6%	5.7%	5.8%
800	3.6%	4.8%	5.2%	5.5%	5.7%	5.9%	6.0%
700	3.7%	5.0%	5.4%	5.7%	6.0%	6.1%	6.2%
600	4.0%	5.3%	5.7%	6.0%	6.2%	6.4%	6.6%
500	4.2%	5.6%	6.0%	6.3%	6.7%	6.9%	7.0%
400	4.5%	6.0%	6.6%	6.9%	7.2%	7.4%	7.5%
300	5.0%	6.8%	7.3%	7.7%	8.0%	8.2%	8.4%
200	5.9%	7.9%	8.5%	9.0%	9.5%	9.7%	9.9%
100	8.0%	10.7%	11.5%	12.3%	12.8%	13.1%	13.3%
900 and 900	3.6%	4.8%	5.2%	5.5%	5.7%	5.9%	6.0%
800	3.7%	5.0%	5.4%	5.7%	5.9%	6.0%	6.2%
700	3.8%	5.1%	5.5%	5.9%	6.1%	6.2%	6.4%
600	4.1%	5.4%	5.8%	6.1%	6.4%	6.6%	6.8%
500	4.3%	5.7%	6.1%	6.6%	6.8%	7.0%	7.1%
400	4.6%	6.1%	6.7%	7.0%	7.3%	7.5%	7.7%
300	5.1%	6.8%	7.4%	7.8%	8.1%	8.3%	8.5%
200	5.9%	8.0%	8.6%	9.2%	9.5%	9.8%	10.0%
100	8.0%	10.7%	11.6%	12.3%	12.7%	13.2%	13.4%
800 and 800	3.8%	5.1%	5.5%	5.8%	6.0%	6.2%	6.3%
700	4.0%	5.3%	5.7%	6.0%	6.2%	6.4%	6.6%
600	4.2%	5.5%	5.9%	6.3%	6.6%	6.8%	6.9%
500	4.3%	5.8%	6.2%	6.7%	7.0%	7.1%	7.3%
400	4.7%	6.2%	6.8%	7.2%	7.5%	7.6%	7.8%
300	5.2%	6.9%	7.5%	7.9%	8.2%	8.4%	8.6%
200	6.0%	8.0%	8.7%	9.3%	9.6%	9.9%	10.1%
100	8.1%	10.8%	11.8%	12.4%	12.9%	13.2%	13.5%

(CONTINUED)

TABLE 34 (CONTINUED)

DIFFERENCES REQUIRED FOR SIGNIFICANCE ACCORDING TO SAMPLE SIZE

SIZE OF SAMPLES COMPARED	OBSERVED PERCENTAGE						
	10% or 90%	20% or 80%	25% or 75%	30% or 70%	35% or 65%	40% or 60%	50%
1800 and 1800	2.5%	3.4%	3.6%	3.8%	4.1%	4.2%	4.3%
1600	2.6%	3.5%	3.7%	4.1%	4.2%	4.3%	4.4%
1400	2.7%	3.6%	4.0%	4.2%	4.4%	4.5%	4.6%
1200	2.8%	3.8%	4.2%	4.4%	4.6%	4.7%	4.8%
1000	3.0%	4.1%	4.4%	4.6%	4.8%	4.9%	5.0%
800	3.2%	4.4%	4.7%	5.0%	5.2%	5.3%	5.4%
600	3.6%	4.8%	5.2%	5.5%	5.7%	5.9%	6.0%
400	4.3%	5.6%	6.1%	6.4%	6.8%	6.9%	7.1%
200	5.7%	7.6%	8.2%	8.7%	9.0%	9.3%	9.5%
1600 and 1600	2.7%	3.6%	4.0%	4.2%	4.3%	4.4%	4.5%
1400	2.8%	3.7%	4.1%	4.3%	4.5%	4.6%	4.7%
1200	2.9%	3.8%	4.3%	4.5%	4.7%	4.8%	4.9%
1000	3.1%	4.2%	4.5%	4.7%	4.9%	5.0%	5.1%
800	3.3%	4.4%	4.8%	5.1%	5.3%	5.4%	5.5%
600	3.6%	4.9%	5.3%	5.6%	5.8%	5.9%	6.1%
400	4.3%	5.5%	6.1%	6.6%	6.8%	7.0%	7.1%
200	5.7%	7.6%	8.3%	8.7%	9.2%	9.4%	9.6%
1400 and 1400	2.9%	3.8%	4.2%	4.4%	4.6%	4.7%	4.8%
1200	3.0%	4.1%	4.4%	4.6%	4.8%	4.9%	5.0%
1000	3.1%	4.3%	4.6%	4.8%	5.0%	5.2%	5.3%
800	3.4%	4.5%	4.9%	5.2%	5.4%	5.5%	5.6%
600	3.7%	5.0%	5.4%	5.7%	5.9%	6.1%	6.2%
400	4.4%	5.8%	6.2%	6.7%	6.9%	7.1%	7.2%
200	5.8%	7.7%	8.3%	8.8%	9.2%	9.5%	9.7%
1200 and 1200	3.1%	4.2%	4.5%	4.8%	5.0%	5.1%	5.2%
1000	3.2%	4.4%	4.7%	5.0%	5.2%	5.3%	5.4%
800	3.5%	4.7%	5.0%	5.3%	5.5%	5.7%	5.8%
600	3.8%	5.1%	5.5%	5.8%	6.0%	6.2%	6.3%
400	4.4%	5.9%	6.3%	6.8%	7.0%	7.2%	7.4%
200	5.8%	7.8%	8.4%	8.9%	9.3%	9.6%	9.8%
700 and 700	4.1%	5.4%	5.9%	6.2%	6.4%	6.7%	6.8%
600	4.3%	5.7%	6.1%	6.4%	6.8%	7.0%	7.1%
500	4.5%	5.9%	6.4%	6.9%	7.1%	7.3%	7.5%
400	4.8%	6.3%	6.9%	7.3%	7.6%	7.8%	8.0%
300	5.3%	7.1%	7.6%	8.0%	8.4%	8.6%	8.8%
200	6.1%	8.2%	8.8%	9.4%	9.8%	10.0%	10.2%
100	8.2%	10.9%	11.8%	12.5%	13.0%	13.3%	13.6%
600 and 600	4.4%	5.9%	6.3%	6.8%	7.0%	7.2%	7.4%
500	4.7%	6.1%	6.7%	7.1%	7.4%	7.6%	7.7%
400	4.9%	6.6%	7.1%	7.5%	7.8%	8.0%	8.2%
300	5.4%	7.2%	7.8%	8.2%	8.6%	8.8%	9.0%
200	6.2%	8.3%	9.0%	9.6%	9.9%	10.2%	10.4%
100	8.2%	11.0%	12.0%	12.6%	13.1%	13.5%	13.7%
500 and 500	4.8%	6.4%	7.0%	7.4%	7.7%	7.9%	8.0%
400	5.1%	6.9%	7.4%	7.8%	8.1%	8.4%	8.5%
300	5.6%	7.5%	8.0%	8.5%	8.8%	9.2%	9.3%
200	6.3%	8.5%	9.3%	9.8%	10.2%	10.4%	10/6%
100	8.4%	11.1%	12.1%	12.8%	13.3%	13.6%	13.9%
400 and 400	5.4%	7.2%	7.8%	8.2%	8.6%	8.8%	9.0%
300	5.8%	7.8%	8.4%	8.9%	9.3%	9.6%	9.8%
200	6.7%	8.8%	9.6%	10.1%	10.5%	10.8%	11.0%
100	8.5%	11.4%	12.4%	13.1%	13.6%	13.9%	14.2%
300 and 300	6.2%	8.3%	9.0%	9.6%	9.9%	10.2%	10.4%
200	7.0%	9.3%	10.1%	10.6%	11.1%	11.4%	11.6%
100	8.8%	11.8%	12.7%	13.5%	14.0%	14.5%	14.8%
200 and 200	7.6%	10.2%	11.0%	11.6%	12.1%	12.5%	12.7%
100	9.4%	12.5%	13.5%	14.4%	14.9%	15.3%	15.6%
100 and 100	10.8%	14.5%	15.6%	16.5%	17.2%	17.7%	18.0%

August 25, 1980
NUMBER 1010.4

Department of Defense Directive

ASD(HA)

SUBJECT: Alcohol and Drug Abuse by DoD Personnel

References:
- (a) Public Law 92-255 (86 Stat 65), as amended
- (b) Public Law 91-616 (84 Stat 1848), as amended
- (c) Public Law 92-129 (85 Stat 361), as amended
- (d) Federal Personnel Manual Supplement 792-2, Feb 1980
- (e) through (i), see enclosure 1

A. PURPOSE

1. This Directive states the DoD alcohol and drug abuse prevention policy, and implements the standards contained in references (a) through (d).

2. In addition, this Directive establishes policy concerning drug abuse paraphernalia.

B. APPLICABILITY

The provisions of this Directive apply to the Office of the Secretary of Defense, the Military Departments, the Organization of the Joint Chiefs of Staff, the Unified and Specified Commands, and the Defense Agencies. The term "Military Services" includes the Army, Navy, Air Force, and Marine Corps.

C. DEFINITIONS

The following definitions are for operational use within the Department of Defense. They do not change definitions in statutory provisions and those regulations and directives that are concerned with determination of misconduct and criminal or civil responsibilities for persons' acts or omissions.

1. Alcohol and Drug Abuse. The use of alcohol and/or other drugs to an extent that it has an adverse effect on the user's health or behavior, family, community, or the Department of Defense and/or the illegal use of such substances.

2. Drug Trafficking. The illegal or wrongful introduction of drugs into a military installation, with the intent of selling or transferring the drugs; or the illegal or wrongful sale, transfer, or distribution of drugs as they are listed in current schedules of the Controlled Substances Act (reference (e)).

3. Alcohol and Drug Dependence. The reliance on alcohol and/or other drugs following administration on a periodic or continuing basis. Dependence may be psychological or physical, or both.

a. Psychological Dependence. The craving for the mental or emotional effects of a drug that manifests itself in repeated use and leads to a state of impaired capability to perform normal functions.

b. Physical Dependence. An alteration or state of adaptation to a drug after repeated use that results in withdrawal symptoms when the drug is discontinued abruptly and/or the development of tolerance.

4. Drug Abuse Paraphernalia. All equipment, products, and materials of any kind that are used, intended for use, or designed for use, in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of the Controlled Substances Act (reference (e)).

D. POLICY

1. It is the goal of the Department of Defense to be free of the effects of alcohol and drug abuse; of the possession of and trafficking in illicit drugs by military and civilian members of the Department of Defense; and of the possession, use, sale, or promotion of drug abuse paraphernalia. Alcohol and drug abuse is incompatible with the maintenance of high standards of performance, military discipline, and readiness. Therefore, it is the policy of the Department of Defense to:

a. Assess the alcohol and drug abuse and drug trafficking situation in or influencing the Department of Defense.

b. Not induct persons into the Military Services who are alcohol or drug dependent and not hire persons who are alcohol or drug dependent if that dependency impairs job performance.

c. Deter and detect alcohol and drug abuse within the Armed Forces and defense community and drug trafficking on installations and facilities under the control of the Department of Defense.

d. Provide continuing education and training to commanders, supervisors, program personnel, and other military members and civilian employees and their families concerning this policy and effective measures to alleviate problems associated with alcohol and drug abuse.

e. Treat or counsel alcohol and drug abusers and rehabilitate the maximum feasible number of them.

f. Discipline and/or discharge drug traffickers and those alcohol and drug abusers who cannot or will not be rehabilitated, in accordance with appropriate laws, regulations, and instructions.

g. Work in concert with national alcohol and drug abuse prevention programs, maintaining appropriate relationships with governmental and non-governmental agencies.

h. Prohibit members of the Armed Forces, and DoD civilians while on the job, to possess, sell, or use drug abuse paraphernalia.

i. Prohibit the possession or sale of drug abuse paraphernalia by DoD resale outlets to include military exchanges, open messes, and commissaries, and by private organizations and concessions located on DoD installations.

2. The Department of Defense encourages DoD Components to use, as guidance and as a legal background in addressing paraphernalia issues, the Model Drug Paraphernalia Act prepared by the Drug Enforcement Administration, at the request of the President (reference (f)).

3. Programs and standards of care promulgated in execution of this policy for military personnel shall be in compliance with P.L. 92-129 (reference (c)).

4. Programs and standards of care promulgated in execution of this policy for civilian employees shall be in compliance with P.L. 92-255, P.L. 91-616, and FPM Supplement 792-2 (references (a), (b), and (d)).

E. RESPONSIBILITIES

1. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)), or designated representative, is responsible for the development, coordination, and supervision of the DoD alcohol and drug abuse prevention program, in accordance with this Directive and shall:

a. In coordination with the Assistant Secretary of Defense (Manpower, Reserve Affairs, and Logistics) (ASD(MRA&L)), develop and promulgate policies designed to ensure that the DoD alcohol and drug abuse prevention programs reach military members, their families, DoD civilian employees and, to the extent feasible, their families. Programs and standards of care for family members shall be consistent with those for the military and civilian components, with accepted practice in the alcohol and drug abuse area, and with applicable laws and jurisdictional limitations.

b. In coordination with the ASD(MRA&L), issue DoD instructions to implement the DoD alcohol and drug abuse prevention program, with specific attention to the functional areas of assessment, deterrence and detection, treatment and rehabilitation, and education and training.

c. Act as focal point for the Department of Defense for interagency and nongovernmental coordination of national alcohol and drug abuse prevention programs.

d. Evaluate and report upon the effectiveness and efficiency of the DoD alcohol and drug abuse prevention program.

e. Establish a DoD Alcohol and Drug Abuse Advisory Committee to advise on policy and program matters. The Committee shall include representatives of each Military Service, designated by the Military Department concerned, and such other advisors as the ASD(HA), or designated representative, considers appropriate. The Committee charter shall be approved by the ASD(HA).

2. The Secretaries of the Military Departments and Directors of Defense Agencies shall establish and operate programs prescribed by this Directive and supporting DoD instructions. They may make exceptions to the policy contained in this Directive only for legitimate medical, educational, and operational purposes. This authority shall not be delegated.

3. In addition, the Secretaries of the Military Departments shall require appropriate commanders to assess the availability of drug abuse paraphernalia in the vicinity of DoD installations through their Armed Forces Disciplinary Control Boards and in conformity with the Armed Forces Disciplinary Control Boards and Off-Installation Military Enforcement Guidance (reference (g)), and take appropriate action, as prescribed in reference (g), when the availability of drug abuse papaphernalia reveals a threat to the discipline, health, welfare, or morals of the Armed Forces.

F. EFFECTIVE DATE AND IMPLEMENTATION

This Directive is effective immediately. Forward two copies of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days.

W. Graham Claytor

W. Graham Claytor, Jr.
Deputy Secretary of Defense

Enclosures - 1
References

REFERENCES, continued

(e) The Controlled Substances Act, Title II, Comprehensive Drug Abuse and Control Act of 1970 (P.L. 91-513) (21 CFR 1300-1316)

(f) Model Drug Paraphernalia Act, Drug Enforcement, March 1980, Vol 7, No 1

(g) Armed Forces Disciplinary Control Boards and Off-Installation Military Enforcement (AR 190-24, BUPERSINST 1620-4A, AFR 125-11, MCO 1620-2A, COMDINST 1620.1B)

(h) DoD Directive 1300.11, "Illegal or Improper Use of Drugs by Members of the Department of Defense," October 23, 1970 (hereby canceled)

(i) DoD Directive 1010.2, "Alcohol Abuse by Personnel of the Department of Defense," March 1, 1972 (hereby canceled)

TABLE 1

DEMOGRAPHIC CHARACTERISTICS OF SURVEY RESPONDENTS AND ALL DOD MILITARY PERSONNEL

(PERCENTAGE OF POPULATION)

CHARACTERISTIC	TOTAL SURVEY	DOD ACTUAL[1]
SEX		
MALE	91	92
FEMALE	9	8
RACE/ETHNIC		
WHITE/CAUCASIAN	71	73
AFRO AMERICAN/BLACK	18	19
HISPANIC	5	4
ORIENTAL/ASIAN/PACIFIC ISLANDER	3	1
AMERICAN INDIAN/ALASKAN NATIVE	1	2
OTHER	2	1
MARITAL STATUS		
MARRIED	53	52
NOT MARRIED	47	48
AGE		
17 OR UNDER	1	1
18-25	55	56
26-29	15	14
30-34	13	13
35-39	10	10
40 OR OVER	6	6

[1] MARCH 1980: DEFENSE MANPOWER DATA CENTER

ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

HEALTH AFFAIRS

21 JUL 1981

MEMORANDUM FOR THE DEPUTY SECRETARY OF DEFENSE

SUBJECT: First Quarter 1981 Assessment of the Drug and Alcohol Abuse Situation - INFORMATION MEMORANDUM

Following is an assessment of drug and alcohol abuse activity in the 1st Quarter, 1981. The purpose of this report is to document trends, increases and decreases in activity rather than absolute or prevalence figures. That data is derived from surveys, the last of which was conducted in February - April 1980 by Burt Associates, Inc. It is hoped that this report will be used to check on the overall progress of current programs to see if they are receiving the emphasis needed to fulfill their purposes.

Since the advent of Southwest Asia heroin onto the drug scene, an issue of compelling interest has been whether that heroin is infecting U.S. military forces. Apparently, the path of the SWA heroin traverses the Middle East-Mediterranean areas into Western Europe and from there to the East Coast of the United States. SWA heroin has been seen in the larger Eastern cities. The question is: has it invaded the military installations? To determine this and the incidence of other serious drugs a special urinalysis laboratory report was instituted to report on the morphine (into which heroin metabolizes), cocaine and phencyclidine positives seen in the geographically scattered laboratories. As of the end of March 1981, the results have shown the following:

- SWA heroin has unquestionably appeared on the military scene in Europe.
- SWA heroin is not being seen in quantity among the military on the East Coast or elsewhere in the United States.
- Cocaine is being used extensively in Europe, Panama and on the West Coast.
- Little phencyclidine is seen; an exception is Camp Lejeune where a number of positives appeared.

The workloads of all urinalysis laboratories except the Schofield Barracks Laboratory rose slightly or remained the same during the period. The rise in the Schofield Barracks Laboratory workload resulted from taking over the Camp Zama Laboratory workload since that laboratory closed.

The number of drug and alcohol abusers refused entry into the Armed Forces at the Armed Forces Examining and Entrance Stations continues to be small. Ninety-seven drug abusers and 39 alcohol abusers were rejected during the quarter out of 60,000 examined.

The number applying for exemption in all services is up slightly thus reversing a steady downward trend. In all instances the numbers continue to be small; the largest for the quarter was 330 from the Army.

Admissions into drug rehabilitation remained generally the same in the Army and Air Force and increased in the Marine Corps.

Admissions into alcohol rehabilitation increases slightly in the Army and remained about the same in the Marine Corps and Air Force.

The Navy's drug and alcohol rehabilitation admissions seemed to have dropped significantly. However, upon investigation this was found to be an abberation. The Navy had made some changes in its reporting system and all of the difficulties in the system had not yet been worked out.

The deaths data is too unreliable to permit other comment. The only figures which exhibit any credibility is the reported Air Force automobile accidents with alcohol involvement -- they average about 15 per quarter.

There are no quarterly data available on administrative discharges or on Uniformed Code of Military Justice activities. However, the year end UCMJ data show a slight upward trend in disciplinary actions taken when drugs were involved.

There are no Veterans Administration admissions data available. The report in which that data appeared ceased publication at the end of 1979.

signed
John H. Moxley III, M.D.

December 5, 1980
NUMBER 1010.5

Department of Defense Instruction

ASD(HA)

SUBJECT: Education and Training in Alcohol and Drug Abuse Prevention

Reference: (a) DoD Directive 1010.4, "Alcohol and Drug Abuse by DoD Personnel," August 25, 1980

A. PURPOSE

This Instruction states the DoD education and training policy in execution of reference (a).

B. APPLICABILITY

The provisions of this Instruction apply to the Office of the Secretary of Defense, the Military Departments, the Organization of the Joint Chiefs of Staff, the Unified and Specified Commands, and the Defense Agencies. The term "Military Service" refers to the Army, Navy, Air Force, and Marine Corps.

C. DEFINITIONS

1. Training. Those teaching and learning functions that develop or improve the competence of health care professionals and paraprofessionals and those DoD personnel responsible for supervision or execution of alcohol and drug abuse prevention programs.

2. Education. Those teaching and learning functions that indoctrinate, orient, or inform personnel about the DoD alcohol and drug abuse prevention programs and resources.

3. DoD Civilian Employee. A permanent employee of the Department of Defense who is a U.S. citizen and who is paid from appropriated or nonappropriated funds.

D. POLICY

1. The Department of Defense shall educate and/or train all military commanders, military and civilian supervisors, and program personnel concerning DoD alcohol and drug abuse prevention policy and effective measures to alleviate problems associated with alcohol and drug abuse. Other military and civilian members shall also be provided appropriate alcohol and drug abuse education. To the extent feasible, education shall be offered to family members on a voluntary basis.

2. Specific education or training shall be developed for each of the following groups and shall include references to both the military and civilian aspects of the program.

a. Military Personnel

(1) At Initial Entry

(a) Enlisted Personnel. The emphasis of initial entry alcohol and drug abuse education shall be on prevention. Desired behavior, credible role models, and healthy alternatives shall be presented as well as the disciplinary, career, and health consequences of abuse. Recruits shall also be made aware of counseling and treatment resources and procedures and their responsibilities, not only to themselves but to their peers. Alcohol and drug abuse instruction shall be compatible with the indoctrination of recruits in the standards of discipline, performance, and behavior required by their particular Military Service. This education shall be completed before the recruit reports to the first permanent duty station.

(b) Officer and Warrant Officer Candidates. Education for cadets, midshipmen, and other officer and warrant officer candiates shall, in addition to (a), above, emphasize the duties and responsibilities of junior leaders in the alcohol and drug abuse prevention effort, to include their responsibilities in creating and maintaining military discipline and enforcement of the law. The causes, symptoms and prevalence of abuse, intervention and referral techniques, and post-treatment responsibilities of junior leaders shall also be addressed. Education shall be completed before commissioning or within 90 days after entry on active duty.

(c) Health Care Professionals. During initial orientation classes, training shall be conducted in the diagnosis, counseling, treatment, and referral of alcohol and drug abusers, as appropriate, and in the DoD policy regarding abuse.

(d) Program Staff. Training shall normally be conducted and completed not more than 60 days after assignment for professionals and paraprofessionals assigned to alcohol and drug abuse program staffs in those areas relevant to their specific duties.

(2) At Permanent Change of Station (PCS)

(a) Service Members (E-1 through E-4). Education shall be conducted within 60 days after each PCS and shall emphasize the legal consequences of abuse under both the Uniform Code of Military Justice and the local laws, and the alternatives to abuse available at the local installation and neighboring community.

(b) Leaders (E-5 through E-9 and Officers). Education shall be conducted within 60 days after each PCS and shall emphasize the command-unique elements of the alcohol and drug abuse program, the scope of the local alcohol and drug abuse problem, local military and civilian resources, opportunities for continuing education and training, and their responsibilities for the maintenance of military discipline and the enforcement of the Uniform Code of Military Justice.

(3) During Professional or Military Education

(a) Junior Officers (O-1 through O-3) and Noncommissioned Officers (E-5 through E-7). Education shall emphasize the responsibilities of junior leaders in the alcohol and drug abuse prevention program, with particular emphasis on deterrence and detection methods, enforcement, counseling, motivation skills, intervention and referral techniques, and methods for monitoring the progress of identified abusers in the unit.

(b) Middle Grade Officers (O-4 and O-5) and Senior Noncommissioned Officers (E-8 and E-9). Education shall emphasize the role and responsibilities of senior leaders in the function of their installation or major command's alcohol and drug abuse prevention program. Areas of particular focus shall be the influence of the senior leader's attitude about alcohol and drug abuse on subordinates, the reasons for and benefits derived from the DoD alcohol and drug abuse program, and the problem of stigma and strategies for diminishing it.

(c) Senior Grade Officers (O-6 and above). Education shall emphasize the need for vigorous command support for the alcohol and drug abuse program, the law enforcement, prevention, and performance aspects of the problem, the federal response, and the intervention techniques for senior and executive-level personnel.

(d) Health Care Personnel. Continuing education and training shall be provided for health care professionals in those areas of alcohol and drug abuse relevant to their duties. Areas of particular focus shall be intervention, diagnosis, counseling, treatment, and referral.

(e) Program Staff. Continuing education and training shall be made available for the program staff, especially for those involved in the rehabilitation process. Areas of particular focus shall be intervention, counseling, and educational techniques.

(4) After an Alcohol or Drug-Related Incident. Motivational education shall be provided for identified abusers who are not physically or psychologically dependent. Normally, education shall be conducted after duty hours and shall focus on the influence of the peer group on behavior, the identification and clarification of the attendee's attitudes and values, the impact and consequences of continued abuse, and the application of decision-making skills to resolution of the attendee's alcohol and/or drug abuse problem.

b. DoD Civilian Employees

(1) Nonsupervisors. Orientation shall be conducted on DoD policy and Military Service or DoD Component programs regarding alcohol and drug abuse within the first 6 months of initial employment by the Department of Defense. Orientation shall emphasize the legal, career, and health consequences of abuse and the counseling, treatment, and rehabilitation opportunities available.

August 12, 1981
NUMBER 1010.6

Department of Defense Instruction

ASD(HA)

SUBJECT: Rehabilitation and Referral Services for Alcohol and Drug Abusers

References:
(a) DoD Directive 1010.4, "Alcohol and Drug Abuse by DoD Personnel," August 25, 1980
(b) Public Law 93-282, "The Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974 (88 Stat. 125)

A. PURPOSE

This Instruction states the DoD rehabilitation and referral services policy in execution of reference (a).

B. APPLICABILITY

The provisions of this Instruction apply to military personnel and civilian employees of the Office of the Secretary of Defense, the Military Departments, the Organization of the Joint Chiefs of Staff, the Unified and Specified Commands, and the Defense Agencies (herein referred to as "DoD Components").

C. DEFINITIONS

1. Detoxification. Planned management of the alcohol and drug withdrawal processes. Medical detoxification is accomplished on an inpatient basis and includes withdrawing alcohol and other drugs of abuse from the individual and providing indicated medical and psychological support.

2. Rehabilitation. The process of restoring to effective functioning persons impaired by the use of alcohol or drugs.

3. Residential Rehabilitation. Rehabilitative services provided on a 24-hour, live-in basis for those who abuse alcohol or drugs.

4. Nonresidential Rehabilitation. Rehabilitative services provided on a nonlive-in basis for those who abuse alcohol or drugs.

5. Referral. Information and/or assistance provided to those who abuse alcohol or drugs for locating appropriate rehabilitative services, ancillary services, or community support groups.

6. Rehabilitation Personnel. Trained members of the alcohol and drug abuse program staff qualified to provide consultative, rehabilitative, or referral services.

7. Support Staff. Members of an alcohol and drug abuse rehabilitation or referral program whose primary work activities involve clerical, housekeeping, security, laboratory, recordkeeping, or other nonmanagerial functions necessary for the overall clinical and administrative operation of the program.

D. POLICY AND PROCEDURES

1. It is the policy of the Department of Defense to be free from the effects of alcohol and drug abuse to maintain high standards of performance, military discipline, and readiness. Therefore, the Department of Defense shall rehabilitate the maximum number of those who abuse alcohol or drugs by providing quality-assured residential, nonresidential, consultative, and/or referral services to such individuals and, when feasible, to their family members.

2. Specific policy guidance shall be developed by DoD Components for each of the following services, when they are provided.

a. Residential Rehabilitation

(1) Staff

(a) DoD Components shall develop criteria that determines the minimum number of appropriately trained professionals, rehabilitation personnel, and support staff required to ensure program effectiveness.

(b) Staff members shall be under the direct supervision of a person qualified to evaluate their performance.

(c) Staff members shall be afforded the opportunity to continue their professional growth and development.

(2) Program

(a) Therapeutic Concept. The program's philosophy of residential rehabilitation shall reflect a multidisciplinary, reality-centered approach.

(b) Program Entry and Termination Criteria

1 Criteria shall be established to determine the eligibility of clients for admission. Intake procedures shall involve a command consultation, a medical assessment to include the type of detoxification required, and a social evaluation that identify the client as requiring rehabilitative services appropriate to the level of care provided at the residential facility.

2 Criteria for termination of residential services shall be established and incorporated in the initial rehabilitation plan.

(c) Clinical Support Services. There shall be a written plan to describe the provision and organization of clinical support services to meet identified client needs, such as, physical and psychological assessment, medical support, nutritional guidance, and physical conditioning.

(d) Program Components. Program components shall be designed to meet fundamental client needs. Documentation of initial and ongoing assessment shall include assessment of these needs.

(e) Family Involvement. Initial client assessment shall include family data. A plan for family involvement in rehabilitation shall be included when feasible.

(f) Aftercare. Programs shall include an individualized plan designed to identify continued support of the client. This plan shall be forwarded to the nonresidential facility servicing the command to which the client is assigned.

(3) Quality Assurance

(a) To ensure adequate client care monitoring there shall be individual case review. The residential rehabilitation care planned and provided shall be updated according to the needs of each client. In addition, supervisory and consultative personnel shall schedule regular, periodic, or random case evaluations to review the original diagnosis, recovery plan, progress of the client, and overall appropriateness of the rehabilitation services provided.

(b) To ensure adequate client record maintenance, client records shall be reviewed periodically by supervisory and appropriate consultative personnel. The care provided shall be accurately documented in a complete, timely, and appropriate manner.

(c) Case evaluations and reviews shall be in compliance with the confidentiality requirements of P.L. 93-282 (reference (b)).

b. Nonresidential Rehabilitation

(1) Staff

(a) DoD Components shall develop criteria that determine the minimum number of appropriately trained professionals, rehabilitation personnel, and support staff required to ensure program effectiveness.

(b) Staff members shall be under appropriate supervision.

(c) Staff members shall be afforded the opportunity to continue their professional growth and development.

(2) Program

(a) Therapeutic Concept. The program's philosophy of nonresidential rehabilitation shall reflect a multidisciplinary, reality-centered approach.

(b) Program Entry and Termination Criteria. Criteria shall be established to determine the eligibility of clients for entry. Intake procedures shall involve a command consultation and a clinical assessment that identify the appropriate rehabilitative services required. Criteria to be met for termination of nonresidential services shall be established by DoD Component policy. The appropriate commanding officer, in conjunction with the rehabilitation staff, shall determine the length of the individual's rehabilitation program.

(c) Program Components. Program components shall be designed to meet fundamental client needs. Documentation of initial and ongoing client assessment shall include consideration of these needs.

(d) Family Involvement. Initial clinical assessment of the identified client shall include family data. Family involvement in rehabilitation shall be included when feasible.

(e) Post Rehabilitation. Programs shall assist the individual in developing a continuing support plan.

(3) Quality Assurance

(a) To ensure adequate client care monitoring there shall be individual case review. The nonresidential rehabilitation care planned and provided shall be updated according to the needs of each individual client. In addition, supervisory and consultative personnel shall schedule regular, periodic, or random case evaluations to review the original assessment, recovery plan, progress of the client, and overall appropriateness of the rehabilitation services provided.

(b) To ensure adequate client record maintenance, client records shall be reviewed periodically by supervisory and appropriate consultative personnel. The care provided shall be accurately documented in a complete, timely, and appropriate manner.

(c) Case evaluations and reviews shall be in compliance with the confidentiality requirements of P.L. 93-282 (reference (b)).

c. Referral Services

(1) Staff

(a) Programs shall have a sufficient number of staff trained in problem assessment and referral.

(b) Technical supervision and assistance shall be made available to the staff.

(c) Staff members, to include civilian additional duty personnel, shall be afforded the opportunity to continue their professional growth and development.

(2) Program

(a) Guidelines

1 Component programs shall offer referral services on a routine basis.

2 Procedures shall be established that specify the mechanism by which and the conditions under which referrals are made.

3 There shall be documentation of the number of individuals screened and the type of referrals made.

(b) Client Assessment. Client assessment shall determine the need for further assessment or rehabilitation services.

(c) Referral Resources. A complete list of available rehabilitation and community support services shall be maintained.

(d) Follow-up. A plan shall be established to obtain a follow-up report from the receiving agency within a designated period of time.

(3) Quality Assurance. Periodic reviews shall be conducted to evaluate the quality and completeness of intake activities, the appropriateness of the referral, follow-up actions and, to the extent possible, the quality of care provided by the referral resource. Follow-up actions and reviews shall be in compliance with the confidentiality requirements of P.L. 93-282 (reference (b)).

d. Program Evaluation

(1) An evaluation program shall be established to measure the extent to which services provided meet organizational needs, program goals, and objectives.

(2) All aspects of rehabilitation and referral systems shall be evaluated to determine program effectiveness and proper allocation of resources.

E. RESPONSIBILITIES

Heads of DoD Components shall implement the intent and standard of this Instruction.

F. EFFECTIVE DATE AND IMPLEMENTATION

This Instruction is effective immediately. Forward two copies of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days.

Assistant Secretary of Defense
(Health Affairs)

Mr. ZEFERETTI. Thank you for your comprehensive statements.

One of the things you alluded to was the improprieties in our survey and the statistics that were sort of not taken in the best way and the survey not done in a professional way. I am going to let my two colleagues who were there with the task force and compiled the statistics answer to that point. But what I would suggest sir, is whether we use the booklet that you showed us with the statistics that you have as far as your report or whether we use ours we still have a problem within the military and a problem of combat readiness that faces our Nation.

Whether we listen to Mr. Ike Pappas talk about 50, 40, or 20 percent or whatever it is—and I don't allude to what he said because I did not hear what he said—I say to you the problem is there and the problem is real. I would much prefer sir, that you come before this committee and you would say that we have a problem. We want to address it in a way that we can target in on the kind of things that are going to eliminate that inability to have combat readiness at a moment's notice.

Since you did mention the fact you were busy working on the budget—I would have appreciated it if you came here and talked to me about how much in that budget is earmarked for drug treatment and alcohol abuse treatment, how much is in there for intervention and prevention along those lines and sir, what are you doing about those young people that have sensitive positions working on the kind of delicate and sensitive equipment that maybe have a problem and can't be replaced immediately because they have a junior officer or superior officer that can't get a replacement and don't have the ability to make that kind of effort immediately?

I would, sir, really have been more appreciative if you came in, not so much with an idea or an attitude that we were here as an adversary but more in line with the attitude that we were here to cooperate and if in fact sir, there is a problem we are here to work toward a solution to that problem. This is the only committee in the House of Representatives that is working on the problems of drug abuse not only in the military but in our society. And yes, we agree sir, that there is a problem and there is a problem with our young people who are asked to come into our armed services. But it would be a better thing I think for all of us if we attacked that problem together, whether it be in the armed services or in our community.

What I would say to you sir, the problems of intervention, prevention, and treatment along with law enforcement is an ongoing effort that we in the Congress have the responsibility of overseeing. Whether we see something that is maybe an average of 26 percent versus 30 or 80 percent, the problem is there, still there, and the problem is still real.

I would say, sir, that I would ask you very, very sincerely, that you join with us in eliminating that problem and if there are statistics that have to be gathered, whether they be gathered by virtue of a system that the military has in effect, whether possibly there is a way of sweeping a couple of things under the rug, because we can't have that kind of jeopardy affecting our armed services or whether it is by virtue of a group of Congressmen and staff going right to the field and asking the men in a closed room without some superior officer around, "Hey fellows what is this all about, what are we doing, how are they helping you and what are you doing on a daily basis."

I think we both have a responsibility to listen to all of it and we have a responsibility to react to it. I say sir, that I am here today as I said in my opening statement—and I am joined by members of this committee—not to be an adversary, not to say to you hey, you have to do something way beyond what we expect of you, but how can we both work together in a cooperative fashion to formulate a kind of strategy that will make some sense.

Mr. English.

Mr. **English**. How long have you been with the Department of Defense in your present position?

Dr. **Beary**. I have been there since the 1st of July.

Mr. **English**. Two months.

Dr. **Beary**. That is right.

Mr. **English**. Did you write your statement?

Dr. **Beary**. The bulk of it yes, I did.

Mr. **English**. Are all the ideas contained therein your own?

Dr. **Beary**. Some of course were developed in conferring with staff but I don't see anything in here I am uncomfortable with.

Mr. **English**. What part of it did you not write?

Dr. **Beary**. It is like looking at wheat and corn that are mixed together and trying to find out what is what. As you work on these things over a period of time I don't know who could tell.

Mr. **English**. So with your vast experience of 2 months you came to these conclusions?

Dr. **Beary**. I have been a physician a good deal longer than that. I have been in science a good deal longer than that. I am saying if you show, if you want to really press the point you should get other opinions than mine. I obviously have a point of view, but if you show this to any high school statistics teacher the blood will drain from her face so I think you have to gather other opinions. I am just giving you my view.

Mr. **English**. Let's move on to other opinions then, doctor.

What was the cost of the survey DOD prepared?

Dr. **Beary**. $400,000 I believe.

Mr. **English**. $400,000 plus or $400,000?

Dr. **Beary**. I will get the exact figure for the record.

Question. What was the exact cost of the Burt Study?

Answer. The 1980 Department of Defense Worldwide Survey of Nonmedical Drug Use and Alcohol Abuse among Military Personnel was completed November 14, 1980, by Burt Associates, Incorporated, at a total cost of $489,224.00.

Mr. **English**. Who conducted the survey?

Dr. **Beary**. Dr. Burt & Associates in Silver Spring.

Mr. **English**. Is it the same Burt & Associates and is this the same survey that the General Accounting Office criticized because the vice president of the firm had worked in the Assistant Secretary of Defense's Office of Drug and Alcohol Abuse Prevention before he went with Burt?

Dr. **Beary**. That is a comment we are well aware of.

Mr. **English**. Dr. Beary you might want to respond to that. I am asking you is that correct?

Dr. **Beary**. I was not working with Mr. Burt. I was at Georgetown at that time.

Mr. **English**. You are not familiar with the criticism?

Dr. **Beary**. I am familiar with it. I don't think it is valid. I will still stand by this as the only statistically valid tool we have. We are going to try to do this every couple of years so we know where we are. Your ruler can't be in inches and mine in centimeters. We have to agree. It is not you I am irritated at. It is the document. I wish you would not misinterpret it as personal.

Mr. **English**. I am not taking it personally. I simply want to point out that we have gone through this song and dance every time that you have been confronted—I should say the Department of Defense has been confronted—with the fact there might be some survey responses that are unfavorable to the military. I also noticed General Louisell was quick to take up on the part that shows improvement for the Army.

We went through this in 1978, the question of whether or not the survey is valid. At that point there were many who said it was not but I noticed when the 1980 survey that came out it was one heck of a lot closer to our survey than were the projections in 1978 by the Department of Defense.

Dr. **Beary**. In the past we have received a going over at these hearings and we have learned to come here with good data and be prepared to defend it. That is why I want to make sure as I start the job we are all thinking on the same wavelength, because I do want to cooperate.

Mr. **English**. I want to clear up the statistical thing. Let's get into that a little more. You are talking about your high school teacher. What was the sample survey in Germany of the Army?

Dr. **Beary**. I will provide that for the record.

Mr. **English**. I will give it to you. It was 660 people at 4 locations.

Dr. **Beary**. What was the confidence level on it?

Mr. **English**. The survey that the committee did was 1,036 samples.

Dr. **Beary**. That doesn't necessarily mean anything. You did not have a random design so if you walked into the area where all the drug abusers were sitting you would find a biased sample. I don't have an unbiased sample.

Mr. **English**. That is a good point because let me also point out that we were taken to those locations by the U.S. officers in charge and I sincerely doubt they are going to take us to the locations where all the drug abusers hang out.

Dr. **Beary**. I don't have a way of saying, but it is not a random way of doing it.

Mr. **English**. Let me also point out General Louisell sitting to your left also accompanied us on all those rounds and he told me when we completed this tour and got back to Andrews Air Force Base he thought it was a very professional approach we had taken to the entire matter. Now the situation in Italy for your information.

The DOD survey included 181 people out of Italy as compared to 548 sailors in Italy in our survey and 222 marines. The Department of Defense survey did not include any marines. It might be a little different that the DOD survey was a worldwide approach as opposed to our approach which concentrated mainly on Germany which we emphasized time and again—and the Naples area—and what has taken place as far as Mediterranean ships there at the time, and we identified those ships that were present.

Do you think that might account a little for the difference between the two surveys and let me point out they are not all that great when one includes the NCO's and particularly the E-5's. Let me point out the differences in the Army where we had the largest sampling between the two. We had 10 percent difference for marihuana use, 49.5 percent when you include the E-5's within our survey. DOD had 39.1. Cocaine, 5.6 as opposed to 5 percent. Heroin, 3.8 for the committee's survey; 4 percent for the Department of Defense. DOD's is even worse than what ours is. As far as uppers, 12.2 percent on the committee's survey, 9 percent as far as the DOD survey. For barbiturates it is 8.1 percent as opposed to 4 percent by DOD.

Let me also point out the survey by the Department of Defense was conducted well over 1 year ago. There just might be more than 2 or 3 or 4 percentage points difference in the two surveys simply because there is more than 12 months difference in time.

I would like to point out to you that perhaps the time and efforts of DOD would be better spent in trying to rationalize and come up with some new and different approaches to solving the drug abuse problem instead of trying to find some way of discrediting the survey and concentrating your efforts on news reports that you don't particularly care for.

I can assure you that no Member of Congress that I know of has any control over the press of this country and what they report.

Thank you very much.

Dr. **Beary**. May I respond that we need data. We can't manage without data. The only data we have is in the Burt report and we plan to do a study like that and improve on it every couple of years.

Mr. **Zeferetti**. Mr. Gilman.

Mr. **Gilman**. Thank you, Mr. Chairman.

Dr. Beary, you have been addressing the problem since July when you came into office, is that correct?

Dr. **Beary**. Yes.

Mr. **Gilman**. General Louisell, how long have you been involved in the narcotics problem in the military?

General **Louisell**. Directly for 20 months in my current assignment and previous to that as a line unit commander since 1951.

Mr. **Gilman**. A good period of time.

General **Louisell**. About 35 years.

Mr. **Gilman**. Is it safe to say we do have a substantial problem with regard to narcotics and and alcohol abuse in the military at the present time?

General **Louisell**. As I mentioned in my statement we have a minimum of 130,000 alcohol dependent individuals in the service. That is very serious.

Mr. **Gilman**. What about narcotics abuse? Do you feel we do or do not have a problem?

General **Louisell**. I should say substance abuse. Not alcohol.

Mr. **Gilman**. Do you feel we do have a problem or we do not have a problem at the present time?

General **Louisell**. We certainly do, sir.

Mr. **Gilman**. Do you feel it is a serious problem?

General **Louisell**. Yes, it is a serious problem.

Mr. **Gilman**. Dr. Beary, do you agree with that?

Dr. **Beary**. Yes, I do.

Mr. **Gilman**. So rather than get all involved in whether we have 5 or 10 percent deviation in statistical analysis the fact remains we have a serious problem out there that has not been corrected. Are we both on the same wavelength?

Dr. **Beary**. That is correct. I just did not want to be held to statistics such as this the next time I might be here. I wanted to make sure we were all talking in the same language.

Mr. **Gilman**. I am not going to argue with you about the accuracy of the statistics. We were out there. We reported to you what we found in confidential surveys with the personnel that are out on the front lines. They had no reason to falsify that information. We presented it to you for whatever value it is to the military. It is our observation that there is a serious problem.

It is apparently your observation that there is a serious problem. The next question is what are we going to do about the problem, what have we been doing about it, what are your future plans for addressing the problem. One of the continual responses that I hear is that the uage is not that much different from civilian life and, therefore, not that bad. For the military to utilize that as a reason for begging away from the question or for not considering it to be that critical seems to me to be inconsistent with the principal mission of the military—to make certain that we have high performance people who are combat ready out on the front line. After all, the people in the civilian population who are overweight or don't have the muscular ability and the physical stamina to do the job are deemed unacceptable for the military.

The fact that there is a high percentage of those people in the civilian population is no excuse for the military not to have high performance and to be physically fit and able to perform.

So, I would hope you are not going to continually refer to that as an excuse for the fact that we have not rid the military of a high amount of drug usage.

Dr. **Beary**. No, sir. In fact I would say I don't view it as an excuse but rather as a reason. In fact, there are many ideas as to why we have so much trouble in the younger group, 18 to 25. One has been alluded to. There has been a failure of families over the past couple of decades. Children when they get to adolescence, when they get to age 17 behave differently and that depends to a certain extent on family structure. Even the best families will have problems but many observers have commented on that.

The other is a risk profile. These people in this group are young, male, single, have a relatively low educational level and another big one on which I know you are all familiar with——

Mr. **Gilman**. That does not justify the military for not meeting a problem head on, does it?

Dr. **Beary**. Absolutely not.

Mr. **Gilman**. You said in your statement you have spent a lot of time on the budgeting since July. I would assume you have been wrestling with the amount of funding which might be available for the health sector of the military?

Dr. **Beary**. That is right.

Mr. **Gilman**. How much funds have you allocated in the next year for taking care of drug treatment and drug abuse in the military as compared to the prior year? Have you increased that, decreased it some, or retained the status quo?

Dr. **Beary**. Mr. Weinberger and Mr. Corlucci have made it clear that anything being discussed before the DRB Board must remain confidential until those decisions are made. As soon as they are, which will be soon, I will get it to you.

Mr. **Gilman**. I am not asking about the new recommendations. I am asking about your recommendations that went into the budget process up until now.

Dr. **Beary**. I guess it is best to sum that up by saying the Secretary realizes this is an important problem and we will build on what we spent.

Mr. **Gilman**. I don't think you understand my question. What were your recommendations? What did you recommend for the budget with regard to the health services, and particularly with regard to substance abuse and treatment?

Dr. **Beary**. I recommended that resources be targeted for deterrence technology particularly to support the portable urinalysis testing program.

I also suggested without being specific that new promising areas of research such as possibly this sweat patch technique, implantable drug delivery systems, et cetera should be carefully observed. I would not want to convey that as a promise that I will have them for you this time next year. Also data collection. Again if we don't have information we cannot design programs. We cannot tell if they are doing any good and so that is essential, that we continue doing studies that everybody agrees are statistically valid. We are always delighted to have input from you gentlemen if you have ways to improve them. Again the basic philosophy would be to slowly tighten the screws until we get this problem to a level that—acceptable is probably the best word—because I have learned to avoid using words like never and always when talking about human biology.

Mr. **Gilman**. Dr. Beary, besides your analysis and besides sweat patches and data collections, were there any other initiatives you recommended?

Dr. **Beary**. Not initiatives I would call specifically my own but General Louisell mentioned in his statement that there will be continuing efforts in the education areas and the other functional areas we have supported in the past.

Mr. **Gilman**. How much did you allocate for urinalysis, sweat patch data, and education efforts?

Dr. **Beary**. I will have to provide those figures to you when the budget process is complete.

Mr. **Zeferetti**. We would welcome those.

[The budgetary figures referred to follow:]

Question. What is the breakdown and description by functional area of budget recommendations made by the Secretary of Defense for combating drug and alcohol abuse for fiscal year 1982–83?

Answer. The projected budget for fiscal year 1982 is as follows:

Identification	$9,754,000
Education	6,769,000
Treatment/rehabilitation	67,608,000
Training	3,545,000
Evaluation	1,618,000
Planning/Coordination	11,246,000
Research	496,000
Total	101,036,000

The projected budget for fiscal year 1983 is not yet available.

Mr. **Gilman**. What did you recommend for the prior year?

Dr. **Beary**. The prior year I was not involved in making that budget but someone on the staff can tell me the figure for urinalysis testing.

Mr. **Gilman**. Can you tell us what your health division has recommended for health services, for substance abuse and alcohol abuse for fiscal year 1981?

General **Louisell**. Congressman Gilman, our budget for 1979, 1980, and 1981 and potential for 1982 has been on a continual rise. Our budget for 1980 was $83 million.

Mr. **Gilman**. What did that include? Did that include all health services for all branches of the military for substance abuse?

General **Louisell**. That talks to all services and is delineated by drug and alcohol abuse prevention.

Mr. **Gilman**. Including treatment and education and testing, the whole works?

General **Louisell**. That is right.

Mr. **Gilman**. $83 million in 1980?

General **Louisell**. $83 million in 1980.

Mr. **Gilman**. What did you spend in 1979?

General **Louisell**. $80 million.

Mr. **Gilman**. What did you allocate for fiscal year 1981?

General **Louisell**. $96 million. These are rounded off. Anticipate $101,036,000 for fiscal year 1982. I would like to offer one comment sir when we talk about money. Going back over the past 20 months of trying to find the best solution we have not found a "magic bullet".

Certainly experience on the committee's trips, on my over 150,000 miles of travel in the last year and half have indicated that we have to take an across-the-board approach. But if there is any one place where we are going to see visible progress—and the only bright spot I see in this whole tragedy of drug and alcohol abuse is the fact that a lot of the corrective action does not cost any money at all.

It is primarily a matter of discipline, of well-planned lifestyles and training and meaningful jobs. These don't cost money. It is a little hard to come before a group such as this and show blood in the form of how much money you are throwing at it. The only bright side of corrective action is that attitudinal and organizational change does not cost a great deal and probably, in my personal opinion——

Mr. GILMAN. If I might interrupt, we talked about the attitudinal change that was needed in 1978 and 1979 and at that time we thought the Defense Department was on the right track. They talked about the need for human behavior professionals being built into the chain of command. It seemed we were moving in that direction but along the way that communication of the high priority of attention on the human behavior element of drug abuse has not seeped down to the lower echelons of command.

We continually heard comment from the troops that they can't get to their commander and talk about their problems. If they have a problem and want to talk about it, they are shuttled aside or they end up in one of the very incompetent drug treatment centers out there in that theater.

You and I heard those comments many times and our analysis shows 75 percent of the men felt that the treatment centers were fair to poor and were not accomplishing their purpose. Apparently, the conception of the importance of this problem has not seeped down.

The attitudinal attention has not reached that portion of the command where it should be. I am curious about what the Defense Department is trying to do about bringing that home to the commanders on the line.

General LOUISELL. You have certainly defined the problem and that particular aspect of drug and alcohol abuse prevention. That is: the education and training of appropriate leaders, professionals, and paraprofessionals to understand, identify, and use the tools that we are putting in their hands.

This past summer, we published a Department of Defense instruction which insists upon drug and alcohol abuse prevention instruction at every level of military schooling, from basic training to the senior service colleges. That is from recruit to colonel. That change is in process.

We have visited some of those schools once this year and are going back to see how much they have improved later in the fall.

Mr. GILMAN. Dr. Beary, do you have any plans for revising the treatment program?

Dr. BEARY. Would you repeat that, sir.

Mr. GILMAN. Do you have any plans for revising the drug treatment program or the alcohol treatment program?

Dr. BEARY. I see what you are getting at because I have been reviewing that literature and talking to professional colleagues about drug and alcohol treatment. There really is not a lot to read in the way of controlled prospective studies.

I would illustrate with an example of a report which I would have to call preliminary since I have not seen it in final print, that said that there was no difference in treatment outcome whether the person with the drug problem got an 8-hour seminar, 1 day of out patient counseling or 28 days of in-patient therapy. This is very disturbing to me.

They all show the same type of effect and one would have to wonder how much of that was just the placebo effect, if you will, of having someone interested in their problems. I could summarize by saying that is an area that somebody has to study. We don't have a research budget any more and it is difficult to get NIDA and the other agencies to do what we are interested in but it is a real problem.

Mr. GILMAN. It sure is a real problem Dr. Beary, and I would hope you would not need a big research study to recognize that the treatment program out there in the field is not very effective. The most effective centers you have are in your field hospitals, and you are cutting back on the funding for the hospitals.

The most effective program you have is in the hospital, but the field programs have been showing a poor result. I would hope you would take a hard look at that aspect of all of this. I would like to ask you one more question.

I know my time has run. Do you have a task force within your department that is giving attention to this whole problem?

Dr. BEARY. I am not sure what you mean by a task force in the sense——

Mr. GILMAN. Who did work on the drug problem?

Dr. BEARY. General Louisell heads the DOD effort and the Assistant Secretary when he arrives and myself would have the input into those programs and communicate with Secretary Weinberger and his assistants as needed.

Mr. GILMAN. I would hope you are going to find some additional initiatives after having reviewed some of our material and having taken another look. I hope you will be taking another look yourself at what is out there besides urinalysis testing and patching and collecting data. I think there is a lot of improvement needed. I think we all have to be working on it, and I hope we can work together to improve this situation.

Dr. BEARY. I agree. I hope I can assemble the sort of report that speaks for itself during my time at the department.

Mr. GILMAN. Thank you.

Mr. ZEFERETTI. Before I call my next colleague—in gathering that data, because you bring in the social aspect of it—I would hope you would find a figure that shows us how many young people come in clean and end up as caught up in either alcohol or drug abuse within the services. That would be helpful to us to see whether or not there is any kind of effective intervention program also that you may have to put into effect because I think that is an important aspect of what we are doing.

If we are talking about doing anything it should be done in a three-pronged kind of effort with intervention, prevention, and treatment being one cycle, and that I think we have to work on together.

Mr. Dornan.

Mr. DORNAN. Mr. Chairman, I am sorry I missed the trip to Europe. In my 5 years here, there is no trip I wanted to go on more in order to bring myself up to speed on what is happening in the military with drug abuse. I remember going to Vietnam as a journalist in 1966 for many reasons, one of them being to see if the rumors back home were true that there was extensive drug use in combat units. I found out there was no problem to speak of. In 1967 on a trip to Vietnam I found the same although there was much comment back home. In 1968 when I got back to the area, there had been an absolute dramatic reversal of what I had first believed. A tremendous increase in drug abuse had occurred, and by the time I went over in 1971 and 1972 particularly in noncombat units, it was all stereo units in the back areas and people sitting around stoned on easily available marihuana and other substances.

The main reason the military people gave—and I thought there was terrific validity in their statements—was that the fallout of the Haight Ashbury days of 1966 and 1967 when the media and covers of news magazines glorified LSD experimentation and drug abuse—that the societal curves on our youth had merely transported itself through the draft process particularly, and the enlistment process overseas.

There was not much argument with that at that time. But in some of the comments that I have heard today, particularly from my colleagues, I have to support the observation that the U.S. military forces are going to have to do much, much, much better than our parents, our schools, and society in general.

It is a tragedy that we have laid upon the military the problems of failure in our school system and failure in high percentages of American parents to teach their kids basic Judao—Christian ethical values; to teach them in some areas sanitary values, to teach them how to read both at home and/or in the schools. It is a tough thing to ask a platoon sergeant or a gunny on a ship to be a parent, but that is exactly what we are asking of our middle management people; to be nursemaids and parents and priests and rabbis and ministers to the young people that we expect to defend our country.

I think the one story that most upset me was in the Berlin garrison. I happened to be going through the Soviet Union in one of five trips and it became apparent in talking to some of our intelligence people in the Embassy in Moscow that the Soviet Union was well aware of our drug abuse problems. I was told that they were banking on it as an additional benefit to them in a combat situation; that they were expecting to blow their way to the North Sea, the English Channel in a matter of days, not weeks, because Western civilization was so decadent and that decadence had transposed itself into the military.

Now, having said all of this I hope nobody argues with me because I think it is true from over five or six trips circumnavigating the globe and talking to defense attachés on myriad problems and always staying close to the military which I have been associated with since I signed up for the Air Force in 1953. I hope we can end this quibbling over statistical data and start—to use the words of the news media—to pay attention to this nightmarish problem when overlaid on a combat situation.

One thing we can address ourselves to with some success is in the area of narcotics control by making it tough and by not having a platoon level person in a position of authority to decide who should stay in or out. Every platoon level leader who decides someone should be kicked out, the base commander, Army commander, and the Pentagon should be aware of every discharge.

Many discharges start the day the recruiters get into competition and bring young men and women into the service who are not going to cut it under a discipline system that they are totally unaware of because they have been crippled by their parents, or intercity situations where they haven't adapted to discipline.

So, let's get together on this. I am going to join the chairman in expressing a little bit of hostility. We must stop quarreling about statistics and move forward on the problem itself. If I were a Soviet commander I would be licking my chops at the thought of taking on soft American kids who are only interested in getting stoned and using Europe as a base of opportunity.

There seems to be a barrier broken monthly and the one area in which we suffer most with the hedonism in this country is lack of ability of our young soldiers and young women coming into the military to come to the toughest combat situation any free nation has ever faced in all of recorded history.

So let's stop quibbling and let's get with it and stop the narcotics abuse in the military. We recognize that our young 24-year-old sergeants and petty officers are supposed to be parents and we are not going to criticize you for that problem that should never have been put on the military of the United States.

Thank you.

Mr. ZEFERETTI. Mr. Guarini.

Mr. GUARINI. I am interested in knowing what kind of recommendations are being made. I know we have a fragmented effort nationally with the Customs and Coast Guard and DEA and FBI and every other branch. The military has their own investigators.

Do you feel there is adequate coordination between these efforts that are made in mosaic form? Are there any recommendations as to how we could have better prevention and intervention of narcotics in the military?

Dr. BEARY. That is a very important point.

Probably the best way for me to address that is to say our office will provide full support for those sorts of efforts. General Louisell has actually been involved in the working level discussions on that and he can give you some specifics of things that are under development.

Mr. GUARINI. I hear a lot of statistics and a lot of talk but I don't see any action programs. I don't hear any recommendations for hard-line programs that we can go forward with. I would like to ask you, General, if you have made any suggestions or recommendations that have not been followed or are there any additional you can make now?

General LOUISELL. I must confess to a certain amount of parochialism over the past 20 months. I have turned most of my attention to the baliwick for which I am responsible and that is the military.

Casting back to my experience prior to that, I do know that at the installation level, the posts such as Fort Sill, Fort Campbell, or Naples, there is an immense amount of working level, practical down-to-earth exchange of information and coordinated actions. A whole series of them—particularly in Germany—you might remember. Operation Snow White in the Frankfurt area was an example of a successful joint and international antidrug operation.

Mr. GUARINI. The bureaucracy is what I am worried about. Have we become dormant because we are not getting enough action into our programs? Exchange of information and statistics is fine. Cooperation is excellent, but the bottom line, the end result, is it there? What kind of hard recommendations should be made?

General LOUISELL. In terms of national effort the Department of Defense has participated in the President's Strategy Council and the so-called Principal Group which assembles the key law enforcement agencies of the United States in one room, include the State Department, FBI, Customs, Coast Guard, and the Attorney General's Office. They have operated and worked in concert; we, DOD, have added our contribution to that and have requested and gotten cooperative endeavors from the other agencies of Government that have responsibility and jurisdiction beyond our particular post boundaries.

We have done a good bit of cooperating with the Central Intelligence Agency and the State Department, and are operative in some of their coordinating groups. We have done more on Europe in the international level.

A classic example, the Drug Enforcement Administration detected, through their intelligence system, a rise of cocaine use on the west coast particularly. They told us about it. We went to our law enforcement and our narcotics intelligence people. They detected the same trend. We went back to our laboratory and told them to test all urinalysis samples for cocaine. We put out a drug alert to the commanders that cocaine use was on the rise and they should learn about it and learn how to inspect for it. It is a simple scenario but it showed the kind of intergovernmental cooperation that directly benefited the Department of Defense side of the house.

There is another example in which we are coming upon narcotics intelligence from sensitive sources and are passing it to those agencies of the Government that should know, such as DEA, State Department, and other agencies.

Mr. GUARINI. I appreciate this but in terms of discipline, prosecution, what do you recommend that should be done that has not been done? Where can we get a better hold on the problem and how can we try to eradicate it?

General LOUISELL. Several months ago the Department would have had a positive recommendation for the Congress concerning the use of urinalysis as evidence but certain opinions, by the Court of Military Appeals, have come through and that was one. Another pertinent opinion that has been handed down establishes that drug abuse off duty is in fact a military offense and that military law enforcement also has jurisdiction over those offenses off post.

Mr. GUARINI. You have more court-martials than ever before concerning this subject matter.

General LOUISELL. I would like to provide our court-martial rates for the record. They are going up slightly in that area. The total number of court-martials is going down because we feel that a court-martial is a last resort. It is a failure of the leadership system. We think it is a good sign when court-martials go down but the proportion of drug and alcohol abuse offenses is up. I will provide that for the record.

Question. What is the data for courts martial, by Service, due to drug and alcohol abuse, for the past five to six years?

Answer:

	Army	Navy	Marine Corps	Air Force
1980	1,996	994	547	582
1979	1,928	911	480	372
1978	1,401	759	522	260
1977	1,699	817	636	301
1976	2,654	860	967	311
1975	2,421	840	1,214	369

Mr. GUARINI. We talk about users in the military and treatment for users, but could you comment on pushers in the military services. What do we do to ferret them out? How serious are pushers within the military?

General LOUISELL. You will find that commanders are extremely stern when they find pushers. I would like to go back to my previous experience at a military post for 2½ years in which I was directly involved in that kind of thing.

We had five major drug-pushing rings operating off the post and run by civilians. Those five rings had tentacles which came on the post. By the time it came down the hierarchy of drug pushers it gets down to a very, very low level where we would find soldiers selling enough to keep their own supply and make a little extra cash. We also found out that the major thrust had to be cooperation with the civilian law enforcement agencies so that they could get to the head of the operation. In that 2½ years we got one out of five.

Mr. GUARINI. But has the ring of pushers become more intensified and better organized in the military?

General LOUISELL. No, sir. There is no evidence from the people I have talked to, and I have been to over 150 locations over the past year. There is not any real change in the sophistication, the organization, nor the discipline of the drug pusher's apparatus that operate in and around the military.

Mr. GUARINI. Would it be your opinion that there are no more drug pushers who are military men in military service than there were a few years ago when you first came into office?

General LOUISELL. I would not venture to say. I don't think it has gone up. .

Mr. GUARINI. But it has not gone down?

General LOUISELL. I don't know. I would have to derive that from—I can't get them to hold up their hands but I——

Mr. GUARINI. You have statistics?

General LOUISELL. I have statistics that would tend to tell you one of two things; either we are trying harder to find them or we are finding more.

Mr. GUARINI. Now when a person is released into civilian life from the military, and you know or suspect that he is a user or a pusher is there a followup? What is done to see that there is a continuity of information that you have when he returns to civilian life?

General LOUISELL. At the Department of Defense level it is not normally done. However, I do note that it is done at the installation levels particularly with local law enforcement officers who work with our provost marshals and OSI agents. In Germany that has been one of the major changes that has occurred over there. There was a problem in 1978, with soldiers who were deeply involved in the drug trade. They were discharged from the service, went home and returned to Germany or stayed there. At that time there was an information gap between the U.S. military authorities and the German law enforcement agencies. Now we can legally and properly provide to the Germans certain information, not in violation of the Privacy Act, which lets them know that an individual, who has a suspicious background in that particular area, has decided to return to Germany or has been discharged in Germany. This has been a great help to them.

Mr. GUARINI. You say they can follow up. I am asking when these people returned from having traveled all over the world and whatever their involvement with the military was and however sophisticated their habit of drugs became and they go back into the neighborhoods of our Nation and they contaminate those neighborhoods, is there an in-place program where there is a guaranteed absolute followup so we can protect the people back home?

Because you used the word can do in each sentence that you answered the last question, I am concerned about do we have a program in place that we know for sure that we are following up. I think that is an obligation that the Department of Defense has to the people of our country.

General LOUISELL. To the degree the Privacy Act allows that, I believe it is done but not on a coordinated basis. I would like to comment. Somehow, by the thrust of your question, it sounds as if we were a prime source of contaminants for our civilian population. I would hope the impression is not that we are turning out, of the military, contaminated people. The vast majority of our soldiers, sailors, marines, and airmen are separated with an honorable discharge and honorable service behind them. I dare say when they return to their civilian pursuits, that they improve the quality of the civilian community, rather than degrade it.

Mr. GUARINI. It only takes one rotten apple in a barrel doesn't it, sir? I noticed there is an attitude, Dr. Beary when he was testifying was making excuses as to getting the wrong kind of product from civilian life and they come into the military and he has to deal with the family life; they become part of it. I noticed that same attitude from you and I wonder whether we here on a higher government level have to change our attitude and be able to attack the problem in its totality instead of making excuses. I feel we are up to epidemic standards when we talk about the problems of drug abuse in our military.

Do you share that view?

General LOUISELL. Epidemic, no. Endemic, yes.

Mr. GUARINI. What would be the difference in your drawing a line between the two? I saw the statistics and I am concerned and I think the committee is concerned about the degree of contamination we have in our military.

General LOUISELL. Could I ask my medical doctor boss to identify the difference between epidemic and endemic?

Mr. GUARINI. You used the word and I expect you are communicating with us what you mean not what he means.

General LOUISELL. The alcohol abuse in the Armed Forces has probably been with us since——

Mr. GUARINI. I am not talking about alcohol. I am talking about narcotics.

General LOUISELL. Drug abuse started in about 1903 when soldiers were moved into the Panama Canal and marihuana became a drug of abuse in the Armed Forces. Since then, there has been a rise and fall in the Armed Forces paralled to the phenomenon seen in civilian society.

Congressman Dornan mentioned in 1966 when he went to Vietnam that he found almost no instances of drug abuse among combat troops. I was there. I found the same. By 1971——

Mr. GUARINI. I appreciate the history of the last 60 years. I know you are trying to be helpful but I am concerned about where we are today, in this moment of history and where we are going as a country.

I know the history is helpful and it is interesting but basically where are we today? Are you concerned or alarmed as to the extent of narcotics that we have in our military, drug abuse that exists today? Being that you are an official of the Department of Defense in charge of the program are you alarmed at it?

General LOUISELL. I am concerned and duty bound to do something about it.

Mr. GUARINI. But you are not alarmed?

General LOUISELL. Alarm bespeaks panic to me and we don't have time for panic.

Mr. ZEFERETTI. Would you say it is a priority item, sir?

General LOUISELL. Yes, sir, it is a priority item.

Mr. ZEFERETTI. So that means there is enough concern that it should get attention and I think that is what my colleague is trying to get to.

Mr. DeNardis.

Mr. DENARDIS. One brief comment, Dr. Beary, and I have some questions. Statistical tools however sharp or blunt are providing us with a piercing glimpse into the obvious. That is that a mammoth problem exists. I think you have seen by the reaction here that we are not concerned about the precise edge of the tool. We know the problem exists. So do you. I want to deal on a more mundane level; however, but nonetheless serious and ask a few questions of you and your colleagues about education and training.

I think the committee would like to know—I certainly would—what kind of education and training in drug abuse prevention is being given today to officers and to noncommissioned officers? How many classroom hours are devoted to drug abuse prevention in the service academies, in the officer candidate schools, and in the NCO academies? Start with that and I have a few questions to follow.

Dr. BEARY. We do realize that education is an important part in correcting this problem and the services have programs at the entry level to acquaint recruits with this problem. There are periodic refresher courses which vary from service to service. We send our drug and alcohol counselors to continuing education classes where they tend to be apprised of advances in the field and work those advances into their curriculums.

Mr. **DeNardis**. Prevention in education activities is included in the basic training of the recruit in addition to it being a component in the service academies and the officers' and NCO schools?

Dr. **Beary**. Service academies I am not certain about. I know General Louisell has been emphasizing the need for the NCO academies and the officer corps to—in other words the people who really control the units—to have this information.

Would you want to amplify that, Bill.

General **Louisell**. Congressman, in December after a trip through our training and educational institutions we came back dissatisfied with what we saw. There were varying levels of education and command attention to the problem. As you well know, hours of instructions cost money. We returned and published a Department of Defense instruction which prescribes the levels of competence in the drug and alcohol abuse prevention area that we expect to see achieved at each level in the Department of Defense, starting with recruits and going all the way to senior officers at the War College.

Yes, it does include recruits. It includes service members when they are sent from one area to another, such as Korea to Japan so they can be brought up to speed on the threat in that particular area. Substance abuse prevention is actively embedded in the service academies, the staff colleges, and the noncommissioned officers academies' curriculums. We have also provided for certain standards of competence for our professionals and paraprofessionals. It is a comprehensive document. It has only been published about 6 or 7 months. We, in the near future, are going out to make the circuit again to see how well that document is being implemented.

Mr. **DeNardis**. You alluded to the expense involved. Reading between the lines, do you regard education and training an important component in dealing with this problem? If you do not, you are not alone. There are other institutions which tend to dismiss education and training in this area and I want to have a clear picture of where it fits.

Dr. **Beary**. I see what you are alluding to. I would refer that to my earlier statement that there is not good evidence that any one treatment program—I think you might include education as a part of treatment as it often is in many of these areas—to show that it has validity. People have assumptions. They have impressions but the prospective controlled studies do not exist.

General **Louisell**. One more comment. I was at one time Deputy Commandant the "provost," for the Army Command and Staff College; I am aware of what it takes and how much time it takes to embed a new block of instruction. Money is a factor because you have to budget for it and so forth. Fortunately, already included in all of our sophisticated school systems, are human resource development courses. Our approach is to use the case study method with alcohol and drug abuse problems in these human resource development courses.

So we are pushing very hard in the education/training area. It was the first priority effort after we codified the Department's basic policy in a DOD instruction last August. We have attacked the problem of bringing up to speed the educational and training effort in the services. About one-tenth of our fiscal year 1981–82 program, will be spent for education and training.

Mr. DeNardis. Mr. Chairman, I have no further questions.

Mr. Zeferetti. Thank you.

Mr. Oxley.

Mr. Oxley. Let me thank you, Mr. Chairman.

I am the new member on this committee. My question for the General, if I may, is what role does the military police play in the role of drug enforcement in the military?

General Louisell. Military police play a number of roles. First they are on an installation. They are the police force and perform the functions of law enforcement that are typical of a small town. In addition, the Army, for example, has established drug suppression teams manned by trained military policemen. They are trained in undercover work and narcotics intelligence development and exploitation and perform that role quite well.

Mr. Oxley. Is this true on all bases or is this dependent on what kind of drug problem a various base may have?

General Louisell. The answer to both questions is yes. In all except a very small number of military installations, you will find a military police element. They may vary from a detachment to a battalion of 700. When a drug situation on a given post becomes serious enough for the post commander to ask his next higher headquarters for help, the services shift their drug suppression assets around to respond to the threat assessment and to the intelligence that is available.

Mr. Oxley. General Louisell, do you have any figures on the number of military personnel who have been discharged as a result of drug abuse?

General Louisell. Yes, I have them and I would like to provide them for the record.

[The information referred to follows:]

Question. What is the number of Service members who were discharged as a result of alcohol and drug abuse, by Service, for the last five to six years?

Answer:

	Army	Navy	Marine Corps	Air Force
1980	2,864	736	187	1,708
1979	3,767	885	194	1,027
1978	4,317	1,158	190	783
1977	4,502	1,435	266	933
1976	3,790	1,193	304	923
1975	2,932	1,334	612	801

Mr. Zeferetti. Thank you.

Gentlemen, to pick up on what Mr. Oxley just mentioned. Is there any incident or any time that a commandant that might have the problem of a large influx of enlisted people that have drug problems on his base, is he ever called down for anything like that? Is he ever disciplined for letting it get that far out of hand? Is he ever put into a position of maybe not reporting it in the best possible way?

General Louisell. The determination of whether or not to give your boss bad news has always been a tough one in the military. I have to say from my 30 years of experience, I have never worked for anyone that did not want to know the truth and did not want to know it quickly.

Mr. ZEFERETTI. Is he disciplined?

General LOUISELL. I have never seen, in that period of time, a commanding officer identify a problem and be castigated for the identification. I have seen a number of them fail because they did not do anything about it or because they hid it and then it exploded underneath them. I have heard it often but it is not part of my personal experience, and it certainly is not a policy. It is a policy from the Chiefs of services on down, that commanders are responsible for everything their units do or fail to do. Commanders are given the available resources to correct those problems and are held accountable for the results.

Mr. GUARINI. Are there any cases where a commander has swept the problem under the rug and tried to hide the problem and it has been brought to the attention of the Defense Department?

General LOUISELL. No. None have been brought to my attention but I am not so naive as to believe we haven't had commanders of varying quality, over time, in the military. Some of them had their weak moments. I suppose it has occurred.

Mr. GUARINI. Has anybody ever been disciplined or reprimanded for having had an excessive problem under his command to your knowledge?

General LOUISELL. Not to my specific knowledge, no, sir.

Mr. DORNAN. Could I ask a followup question?

General, you said you would supply statistics on who has been discharged. Dr. Beary made some interesting points about reliability of samplings, the precision with which you put something together.

Isn't it possible that someone's job performance can fall so low because of abuse of drugs or alcohol and that he might be discharged because of poor job performance, or that somebody's discipline problems are exacerbated by drugs but he is clever enough to keep that problem hidden from his superiors so he gets a BCD or quick honorable discharge to get rid of him because of his discipline problems with narcotics again may be the cause?

I wonder if we could footnote in as precise a way as possible the accuracy of the statistics where the principal cause for discharge might not be drugs but it might be a contributing factor because of the lack of morale in the particular unit. There might be some suspicion that his job performance is low because of drug abuse.

Also, we will never know the young officers, young managers, that get out of our service, druggies or people who don't know how to respond to discipline, or how many aviators get out because they find someone asleep against the tire of the aircraft who is supposed to be the crew chief.

This happened to me particularly. This man was discharged and he left a tool kit in the intake of the jet engine. We just don't know the fallout of drug abuse throughout the whole range of the military that gets more and more technological requiring more education, better reading skills, better discipline, more self-reliance.

We will just never know the real statistics on drug abuse, and I include alcohol, no matter how accurate you try to make your root statistics on who got kicked out with a BCD for drugs.

So if you could add a little survey so we understand that we are going in the same direction on how flawed the raw statistics may be because there are so many unknowns involved in this Fifth Horseman of the Apocalypse, this drug abuse in our society.

Would you do that?

General LOUISELL. I take it you are asking for a footnote, sir?

Mr. DORNAN. A good one.

General LOUISELL. You will get one.

Mr. ZEFERETTI. Congressman English wants to clear up a couple of questions on the survey.

Mr. ENGLISH. General Louisell, Dr. Beary stated he wanted to bring the drug abuse problem down to acceptable levels.

What would you consider to be acceptable levels?

General LOUISELL. I can't imagine what an acceptable level really is, but I think what Dr. Beary is telling us is that there is an irreducible minimum. Where that minimum is, I don't know. I don't think anyone does yet.

Mr. ENGLISH. We have figures with regard to marihuana use, even using DOD's year old figures, 40 percent, ours are over 45 percent, we have crews using drugs on duty, that is unquestioned, I think. We have a situation of, you mentioned alcohol, in which we have three-fourths of those who have used drugs indicate they also combine that with alcohol, which makes the problem even worse.

To what level do we bring that down to where it is acceptable? There has to be a goal. What are we anticipating, shooting for? Is it possible in your opinion to totally eliminate drug abuse while on duty?

General LOUISELL. No, sir. I don't think it is possible to totally eliminate substance abuse on duty so the limit is not zero.

Mr. ENGLISH. Can we bring it to 1 percent?

General LOUISELL. I have no idea, sir.

Mr. ENGLISH. So you have no idea to what level it is possible to reduce drug abuse on duty; is that correct?

General LOUISELL. The stated goal of the Department is to be free of the effects of drug and alcohol abuse. That is about as noble and possible as the Ten Commandments.

Mr. ENGLISH. How low do you think you could bring it?

General LOUISELL. I don't know. I am not going to hazard a guess. I must say my personal satisfaction level is very, very low figure.

Mr. ENGLISH. Let me point out that you are now looking at instituting a urinalysis test for cannabis. For people who are caught using cannabis, what punishment can they expect?

General LOUISELL. I think that will depend on the decision of the local commander when that situation develops. It has to be that way. It also has to be that way so that we may be fair to a recruit who tried his first cigarette at the urging of one of his buddies and he was caught on the first try. That is adolescent behavior and he needs a rap on the knuckles. This also could be the fourth time that soldier has been caught along with the fact he has been absent without leave. That soldier may receive a fairly swift and severe application of military justice.

Mr. ENGLISH. What you are telling me is that most likely the first time we will chalk that up to adolescent behavior. You get caught with a marihuana cigarette; we will say you are out being one of the boys?

General LOUISELL. If that happens to be in a circumstance where the commander is treating it that way. There are circumstances where the first one is intolerable.

Mr. ENGLISH. You have been a commander. What would be your recommendation to those commanders? What should they do with that person who is detected through a urinalysis test as having used marihuana, hashish, cannabis?

General LOUISELL. If I may I would like to rephrase that. I would not make a recommendation to the commanders because someone will accuse me of command influence, but if it were me in command he would probably get 2 weeks in the correctional custody facility with an opportunity to soldier his way out.

Mr. ENGLISH. How about the second time?

General LOUISELL. I suspect by the second time we would be getting close to looking to see if he were useful for long-term service.

Mr. ENGLISH. Are you talking about the possibility of considering expelling him from the service with a chapter 9 discharge?

General LOUISELL. I would at least be thinking about that.

Mr. ENGLISH. With a chapter 9 discharge?

General LOUISELL. Possibly.

Mr. ENGLISH. That is an honorable discharge. The only difference between that and the regular standard honorable discharge is the fact he can't re-enlist, isn't it?

General LOUISELL. Yes.

Mr. ENGLISH. So you are going to give this person an honorable discharge because he gets thrown out of the service for using drugs?

General LOUISELL. I pointed out in my statement that in the very near future it will be possible to grant an other than honorable discharge for rehabilitation failure or refusal to accept treatment. This policy change is in process.

Mr. ENGLISH. That is something that you are urging; is that correct?

General LOUISELL. Yes. sir.

Mr. ENGLISH. Let me point out with regard to our survey that we show in the Army you have 10 percent using cannabis daily; the Navy shows 24 percent using cannabis daily.

Given the fact that we are looking at somewhere between 40 and 50 percent cannabis use at least once a month or more often, will you recommend with the new urinalysis test that complete sweeps be made of each unit on a regular basis?

General LOUISELL. No, sir.

Mr. ENGLISH. Who will you select out to be tested?

General LOUISELL. We are not going to, sir. We are going to provide those tools to the services and they will develop the policies that suit their particular environment.

Mr. **English**. So you are not going to make any recommendation in that area?

General **Louisell**. Let me be more positive. We are specifically not going to attempt to mandate, as was done in the past with 60 percent of every command, every year. No, sir, we are not going back to that.

Mr. **English**. Let me ask you this then: What do you think is going to happen? If you have a guy out there and say that he has gotten into a fight. Perhaps he has a personality conflict with his commander. What do you figure his chances are of being subjected to a urinalysis test compared to the so-called good soldier?

General **Louisell**. I am not sure I understand the thrust of your question.

Mr. **English**. The question is an individual who may have a personality conflict with his commander or even his sergeant is much more likely to be subjected to such a test, isn't he, left up to the commander's discretion than the so-called good soldier, the guy identified as getting along and doing his job well?

General **Louisell**. No, sir, as I understand it, the use of properly taken urine samples must conform to the rules of search and seizure or must be in the context of a health and welfare inspection; either one.

If you are indicating that there could be a vendetta or a misuse of power by a vindictive sergeant, I doubt seriously that the protection of law is there for that.

Mr. **English**. Let's assume you come and I don't like you and I say, "Louisell, I think you look funny today; why don't you hop over and we will give you a test."

If you have in fact used any kind of marihuana or hashish in the last couple of weeks it is likely it will show up because the THC remains in your system that long.

What is the difference between taking that kind of action and saying, "Old Joe over here, Joe is a good soldier. His MOS is one that is critical to us. We can't afford to lose him. We know he was out smoking pot last night because we saw him but we can't get in and mess him up because we have to have him in the unit and we don't have anybody to replace him."

What is to prevent that sort of action from happening?

General **Louisell**. I doubt that the scenario you propounded—that I just don't look right and I need to give a urine sample—would hold up as meeting the proper rules of search and seizure.

There would have to be more probable cause.

Mr. **English**. That is probable cause.

General **Louisell**. Not unless my eyes were glazed and I staggered.

That is probable cause.

Mr. **English**. It appears to me your eyes look glazed.

General **Louisell**. It is subject to challenge.

Mr. **English**. It is my interpretation. Let me go one step further there. What I am getting at is the Department of Defense in 1975 at Walter Reed conducted their own study. They were involved in this issue. That ceased in 1976 I might state but in 1975 they came up with a good soldier syndrome.

Would you like to explain to the audience what the good soldier syndrome said?

General LOUISELL. I am not familiar with that specific syndrome unless, if it is the halo effect that you hear about all the time. I imagine it means that a man who does well on the job tends to be excused from minor offenses and that another man who does not have that level of performance, might not be excused from those same offenses.

Mr. ENGLISH. Those that are wise enough know that exists within our military and that drug culture contains mostly individuals who are wise enough to understand that if they should have unusual or weird behavior they will be detected. In many cases they have critical jobs. They are smart enough to know how to use drugs without becoming a problem.

The guy that is going to get caught is a guy that is not that swift. He is frankly the dummy that is not smart enough. But that does not make their offense any less than that of the individual who is that smart.

The point I make, it appears to me in fairness if you are going to go after a cannabis problem you will have to do it in total unit sweeps.

General LOUISELL. There will be unit sweeps in high risk areas. I am sure of that.

Mr. ENGLISH. Thank you very much.

Mr. ZEFERETTI. Thank you, gentlemen.

We have a vote on the floor.

I would ask that Maj. Gen. Mary E. Clarke, Maj. Gen. William Usher, Rear Adm. Paul Mulloy, and Brig. Gen. Anthony Lukeman, I would ask them to stay.

We are coming right back and I thank you so much for spending the time with us

I want to assure you too that we, as a committee, and my colleagues on this committee would want me to say this, that the majority of our members of the Armed Forces are to be respected and to be lauded for the kind of service they give to this great Nation and this is no infringement on them.

This is just a way for us to find out how we can help those that need assistance.

Thank you very much.

Ladies and gentlemen, we have prepared statements by each of you. We will make them part of the record, without objection, and you may proceed in any way you wish.

If you want to summarize your statements individually we will be more than happy to do it that way.

I think we can get along a little quicker and get you out of here faster. We are going to invoke the 5-minute rule so we can get you out of here faster.

We apologize for keeping you here this long but it is an important subject. It is something that we have much concern over and again in a cooperative spirit we are trying to find a means that it is possible that we can combat this problem together, and more importantly to recognize first and foremost that it is a problem.

Whether or not these figures are exactly what you think they should be, the fact of the matter is there is a problem and, again, whether or not it is 29 percent or whether it is 50 percent, I think the question has to be addressed.

We look forward to your input into explaining to us possibly some of the processes that you go through and what ways you might want to recommend that you feel that we jointly could make an impact on the overall problem.

I welcome you and thank you for your appearances and you may proceed in any manner you deem comfortable.

General **Louisell**. If it is suitable we could start on our left and work down the table with the summary of the written testimonies.

TESTIMONY OF MAJ. GEN. WILLIAM R. USHER, DIRECTOR, PERSONNEL PLANS, U.S. AIR FORCE

General **Usher**. Mr. Chairman and members of the committee, I am Maj. Gen. William R. Usher, Director of Personnel Plans, Headquarters, U.S. Air Force.

As you have indicated, I will submit my prepared statement for the record and present a brief summary of it.

I appreciate the opportunity to appear before this committee to discuss the efforts made by the U.S. Air Force to combat the effects of drug abuse.

Throughout the 10 years of our program central themes have not changed. Drug abuse is incompatible with the Air Force mission. We do not tolerate it and we hold commanders responsible for preventing it. The Air Force approach to the problem of drug abuse continues to be one of providing commanders at all levels with the policies and resources to deal with the problem.

Drug abuse prevention, rehabilitation and education programs are conducted at all command levels by a cadre of professionally trained officers and NCO's who serve the Air Force in the social action career field. We believe our programs are sound, well-funded, indeed about $26 million a year and some 800 people, well-managed and responsive.

Although we believe our program is the best of its kind we are working hard to further strengthen it. Of course, it has been pointed out earlier today any impact on readiness is unacceptable, and we recognize that drug abuse has an impact on readiness.

But I am bound to say that that effect in the Air Force is quite limited, fortunately. Indeed, it is on the order in terms of identifications of a little over 1 per 100.

The majority of Air Force people are drug-free. They are dedicated individuals who serve the people of this Nation faithfully and at great sacrifice in many places around the world. I will now briefly review our programs, our assessment of the current situation, and some steps we are taking to tighten and toughen our approach.

Our current benchmark of drug use prevalence is the DOD worldwide survey of drug and alcohol abuse conducted by Burt Associates in the spring of 1980.

The findings of this survey confirmed our assessment that our No. 1 substance abuse problem among our ranks continues to be alcohol abuse.

The use of illicit substances is confined almost exclusively to cannabis use by junior enlisted personnel. We have noticed a decline during the past year in the number of those identified for cannabis.

We are, however, concerned with the greater societal acceptance of cocaine and the view of users that it is a safe recreational drug and that that may result in its greater use by Air Force members.

We have seen a small increase in cocaine identifications in the past year. Identifications for other drugs have remained low and have declined since 1978.

The Air Force program has two primary goals, to discourage all drug abuse and to keep the adverse consequences to the Air Force and to the individual to a minimum when abuse does occur. Our primary prevention effort is a comprehensive education process beginning during accession or basic training and continuing throughout a member's career.

We believe our efforts to improve leadership and the quality of life within the Air Force also pay preventive dividends for problems such as drug abuse. Our basic approach to drug rehabilitation is keyed to our identification of abusers at the earliest possible point.

Rehabilitation is reserved for those who truly need it; those whose use represents only a disciplinary problem are punished, provided drug awareness education, and returned to duty when appropriate.

Repeat offenders, traffickers, addicts, and those who do not respond favorably to rehabilitation are considered for appropriate disciplinary and separation action as soon as possible.

In response to a particularly high level of drug availability in Europe and to the threat this situation posed to our military readiness there, we intensified our existing drug abuse control programs in Europe beginning in September 1978.

This effort known collectively as Operation Counterpush is best described as a full court press of the Air Force program against drug abuse involving the combined activities of commanders, law enforcement, and social actions personnel.

The effectiveness of these efforts we believe is reflected in the DOD-wide survey of drug abuse.

In summary, sir, our policy is clear. Drug abuse is absolutely incompatible with Air Force standards.

Our policy on drug abuse has been reiterated to all Air Force personnel frequently but most recently in an August 18, 1981 memorandum jointly signed by the Chief of Staff of the Air Force and the Secretary of the Air Force to all Air Force personnel.

Along with this memorandum we are further toughening and tightening our overall approach to drug abuse through the exercise of strong leadership. We have always held our members to high standards of discipline and accountability, but the need for firm disciplinary action against abusers is again being reemphasized through an ongoing effort to insure that all personnel understand and comply with our policies.

The goal is maximum deterrence of drug abuse and firm, swift action when abuse occurs.

This concludes my summary statement, Mr. Chairman. I will be happy to answer any questions after the others have finished.

[The prepared statement of Major General Usher follows:]

PREPARED STATEMENT OF MAJ. GEN. WILLIAM R. USHER, DIRECTOR OF PERSONNEL PLANS, U.S. AIR FORCE

Mr. Chairman and Members of Committee, I appreciate the opportunity to appear before this committee to discuss the efforts made by the United States Air Force to combat the effects of drug abuse. We have continued to refine the comprehensive drug and alcohol abuse control programs we began more than ten years ago. Throughout this period, the central theme of these programs has not changed: drug abuse is incompatible with the Air Force mission, we do not tolerate it, and we hold commanders responsible for preventing it. An effective response requires: an accurate assessment of the drug threat, which includes drug availability, distribution channels, and prevalence of use; and the ability to effectively focus local resources. The basic objectives of our programs are: prevention of abuse; rehabilitation and correction of identified abusers; and discipline and discharge of those who cannot or will not be rehabilitated.

The Air Force approach to the problem of drug abuse continues to be one of providing commanders at all levels with the policies and resources to deal with the problem. Our regulation (AFR 30-2), which we revised in June of this year, outlines our policy guidelines. Its provisions are tailored by Major Command (MAJCOM) drug and alcohol abuse control staffs to respond to their unique requirements. Drug abuse prevention, rehabilitation, and education programs are carried out at the installation level and managed at the MAJCOM and Air Staff level, by a cadre of professionally trained officers and NCOs who serve in the Air Force Social Actions career field. We believe our programs are sound, well-managed, and responsive.

In 1978 the Air Force provided this committee a thorough description of our programs. We have continued those programs, modifying them according to our experience. My comments today will briefly review our programs, but emphasize our assessment of the current situation and changes made in the past three years.

CURRENT SITUATION

Our current benchmark of drug use prevalence is the DOD worldwide survey of drug and alcohol abuse conducted by Burt Associates in the Spring of 1980. The findings of this survey confirmed our assessment that our number-one substance abuse problem among all ranks continues to be alcohol abuse. The use of illicit substances is confined, almost exclusively, to cannabis use by junior enlisted personnel. Twenty-one percent of our E1-E5 personnel reported using at least one illicit drug within 30 days of the survey. Twenty percent reported using marijuana/hashish (cannabis), four percent reported using amphetamines, and two percent reported using cocaine. Cannabis use by our junior enlisted personnel is, therefore, our second greatest drug problem, accounting for more than 85 percent of our drug identifications for the past four years.

Recent trends in our drug abuse identification figures indicate that while the percentage of identifications for cannabis, as opposed to other drugs, has remained at 85 percent, the total number has declined in the past year: 13.1 per thousand to 10.7 per thousand. Although we continue to be watchful, we have seen no indications that the influx of Southwest Asian heroin predicted by the Drug Enforcement Agency has impacted Air Force personnel. We are, however, concerned that the greater societal acceptance of cocaine, and the view of users that it is a safe, recreational drug, may result in its greater use by Air Force members. We have seen a small increase in cocaine identifications in the past year. Identifications for other drugs have remained low and have declined since 1978.

THE AIR FORCE DRUG THREAT ASSESSMENT PROCESS

Our three-tiered drug threat assessment process is designed to provide local and regional commanders with a timely picture of drug abuse within their command. A key element in the assessment process is the Drug and Alcohol Abuse Control Committee (DAACC).

At the base level (first tier) the DAACC is normally chaired by the senior installation commander or deputy and is made up of representatives from the Drug/Alcohol Abuse Control Office, the Judge Advocate, Security Policy, Office of Special Investigation (OSI), Personnel, Surgeon General, the Chaplain, Safety, and any others the commander deems appropriate. This group makes a local drug threat assessment by systematically analyzing drug abuse indicators such as arrest rates, investigations, accident reports, hospital emergency room trends, judicial and non-judicial actions, drug abuse identification rates, urinalysis results, and drug and alcohol inputs from the regional Armed Forces Disciplinary Control Board and local law enforcement officials. Through this process, commanders are better prepared to take appropriate countermeasures to deal with the specific drug abuse threat they are facing. Countermeasures can include increased law enforcement actions, inspections, education and information programs, and increased urine testing.

Reports from each base-level DAACC are periodically forwarded to major command DAACCs (second tier) where they are compiled and reviewed with similar inputs to provide a command-wide assessment. In 1979 a DAACC management guide was prepared and distributed Air Force wide to assist in standardizing drug assessments. Major Command assessments are forwarded to an Air Staff agency, the Air Force Manpower and Personnel Center (third tier), where they are compiled into an Air Force-wide assessment of the drug threat.

An additional tool for this process is our drug abuse management information system (MIS). This computer system, begun in 1976 and enhanced in 1980, has greatly increased the effectiveness of the operational management of our drug abuse control program. The MIS is a subsystem of the worldwide Air Force automated personnel data system. Identification data for each drug abuser is entered and updated in the base-level personnel computer. Subsequent personnel actions concerning assignment availability, promotion eligibility, and the Personnel Reliability Program are then quality controlled at the base, Major Command, and Air Staff levels. Additionally, demographic data, levels of abuse, method of identification, and type of drug abused are compiled into a comprehenive statistical summary.

Our management information system provides an effective tool to monitor all identified drug abusers until they have been fully returned to duty or discharged, as well as to aggregate drug abuse identification trend data at all three command levels.

THE AIR FORCE DRUG ABUSE CONTROL PROGRAM

The Air Force program has two primary goals: to discourage all drug abuse and to keep the adverse consequences to the Air Force and the individual to a minimum when abuse does occur. One of the more significant changes made in our June 1981 revision to AFR 30-2 included an expanded evaluation process to assist commanders in determining the extent of an individual's drug involvement. Rehabilitation is reserved for those who truly need it; those whose use represents only a disciplinary problem are punished, provided drug awareness education, and returned to duty when appropriate. Repeat offenders, traffickers, addict and those who do not respond favorably to rehabilitation are considered for appropriate discipline and separation action as soon as possible.

PREVENTION/EDUCATION

Our first means of preventing drug abuse in the Air Force is to ensure that we do not access new members with drug abuse histories. Any use of LSD, narcotics, or dangerous drugs, or a conviction for drug possession or trafficking (including marijuana) is disqualifying for enlistment or commissioning. Pre-service use of marijuana alone is not disqualifying, although applicants for Personnel Reliability Program positions must not have used it within six months. Before enlistment all applicants must acknowledge in writing their understanding of Air Force standards concerning drug abuse. Our accession policy toward drug use assures that we do not induct drug dependent individuals, yet it realistically responds to the widespread prevalence of marijuana use among the population from which we draw our recruits.

Our efforts to maintain a drug-free force continue well beyond recruitment. Beginning with accession training programs including Basic Military Training School, Reserve Officer Training Corps, Air Force Academy, Officer Training School and our direct commissioning programs each member attends a drug abuse education program (DAE). Following accession training, all members receive a minimum of two hours DAE within 60 days of their arrival at a new duty station. New duty station DAE is divided into two tracks: supervisory and nonsupervisory. Attendance is determined by grade and duty position. While education at a new duty station continues throughout a member's career, more specific DAE information is integrated into each of our officer and enlisted professional military education programs. Learning objectives in professional military education programs are graduated so that they are relevant to the member's grade and level of responsibility. Beyond accession, new duty station and professional military education DAE, members involved in a drug-related incident attend the eight-hour Drug Awareness Seminar which, while educational, is primarily rehabilitative. The total Air Force Drug Abuse Education program is thoroughly outlined in AFR 30-2 which is provided for the record. Although our DAE program is extensive, drug abuse prevention activities go beyond education. In particular, Drug Alcohol Abuse Control Committees, which assess drug abuse threats, also play an important role by initiating drug abuse prevention activities.

Other Air Force programs and initiatives also contribute to our prevention and education effort. Some examples include: the publication of drug abuse information in internal media, especially base newspaper; the Air Force-wide distribution of National Institute on Drug Abuse and commercially produced drug abuse literature; and special drug abuse presentations by our drug/alcohol abuse control specialists to wives' clubs, civic organizations and community schools. We believe our efforts to improve leadership and the quality of life within the Air Force also pay preventive dividends for problems such as drug abuse.

IDENTIFICATION

There are four methods by which we identify drug abusers: arrest and investigation urinalysis; incident to medical care; and self identification. Since 1978 the percentage of those identified as the result of arrest and investigation has increased from 81 percent to 88 percent. Identifications from urinalysis and incident to medical care have remained constant at five precent and one percent respectively. Self identifications have decreased from 13 percent to 6 percent. Concerning urinalysis, we have found commander-directed testing of suspected abusers to be the most effective approach. It achieves significantly higher confirmed positive rates than random or unit sweep testing and is far less disruptive on our units. For these reasons, we will continue to stress suspect testing and keep the responsibility for it with our commanders, who, incidently, greatly favor this approach.

Our policy toward self identifications is being modified. Since 1971 Air Force members have been able to seek assistance for personal drug abuse under the Limited Privilege Communications Program (LPCP) without receiving disciplinary action or less than honorable discharge as a consequence of revealing that use. We are considering restricting this exemption to only those who have been medically determined to be drug dependent. Those who need help will continue to receive it, but we believe the LPCP should not be available to those experimenters and users who can stop on their own volition.

REHABILITATION

Our basic approach to drug rehabilitation is keyed to identification of abusers at the earliest possible point. Once identified, we thoroughly evaluate the extent of an individual's drug involvement and ensure that any medical consequences of abuse are attended to. Rehabilitation regimens are individually tailored to include all aspects of unacceptable behavior and are geared toward an acceptance of personal accountability and a reaffirmation of Air Force standards.

It is the unit commander's determination as to whether rehabilitation has been successful. Those who cannot or will not remain rehabilitated are discharged. We do not consider a member rehabilitated until he/she can be returned to full duty. In some cases retraining is required. We believe local commanders and personnel officers are in the best position to determine the appropriateness of retraining as a consequence of drug abuse.

EUROPEAN INITIATIVES

In response to the particularly high level of drug availability in Europe and to the threat this situation posed to our military readiness there, we intensified our existing drug abuse control programs in Europe beginning in September 1978. This effort (known collectively as Operation Counterpush) is best described as a "full court press" of the Air Force program against drug abuse, involving the combined activities of commanders, law enforcement, and social actions personnel. Actions have been taken in four major areas: drug suppression; demand reduction; publicity and education; and quality of life improvements. Drug suppression includes joint law enforcement operations with host country officials as well as limited mail inspections. Demand reduction actions are targeted most specifically to the casual user by making it both risky and costly to use drugs, but also include increased frequency and duration of education. Unannounced urine testing levels remain the highest in the Air Force. Drug detector dog teams and law enforcement agents were increased. Drug involvement results in firm disciplinary action in addition to education and counseling.

The effectiveness of these efforts, we believe, was reflected in the DOD-wide survey of drug abuse.

SUMMARY

Drug abuse control policies and programs are thoroughly integrated into every facet of Air Force quality force management. They have been in place for a decade, and have evolved to meet changing conditions. Our policy is clear: drug abuse is absolutely incompatible with Air Force standards. This policy was recently reiterated in a 28 August 1981 memorandum from the Chief of Staff and the Secretary of the Air Force to all Air Force personnel. Along with this memorandum we are further tightening and toughening our overall approach to drug abuse. We have always held our members to high standards of discipline and accountability, but the need for disciplinary action against abusers, in the form of firm punishment, is being readdressed through an ongoing publicity effort to insure that all personnel understand and act on our policies. Those who require rehabilitation will continue to receive it, but all will face the consequences of their actions. The goal is maximum deterrence of drug abuse and firm, swift action when abuse occurs.

This concludes my prepared statement. I would be happy to answer any question you may have.

TESTIMONY OF MAJ. GEN. MARY E. CLARKE, DIRECTOR, HUMAN RESOURCES DEVELOPMENT, OFFICE OF THE DEPUTY CHIEF OF STAFF FOR PERSONNEL, DEPARTMENT OF THE ARMY

General **Clarke**. I am Maj. Gen. Mary E. Clarke, Director of Human Resources Development, Office of the Deputy Chief of Staff for Personnel, Department of the Army.

Accompanying me today is Helen D. Gouin, Director, Army Alcohol and Drug Abuse Program, Office of the Deputy Chief of Staff for Personnel.

I appreciate the opportunity to appear before this committee and to address the programs and initiatives undertaken by the Army in our fight against alcohol and drug abuse.

We share a mutual concern for the effects of alcohol and drug abuse on combat readiness and I am confident that we are making progress in combating this complex problem.

The Army has continued its all-out effort to prevent the abuse of alcohol and other drugs by soldiers, civilian employees, family members, and retired military personnel.

The Army Alcohol and Drug Abuse Prevention and Control program directly supports our commanders. It assists in reducing turbulence primarily through the rehabilitation of personnel in the military environment where substance abuse surfaces, and by returning them to duty as soon as possible.

When rehabilitation fails, we eliminate the military member or civilian employee from Government service in an expeditious manner.

I would like to address the nature and extent of the alcohol and drug abuse problem within the Army.

In the record copy of the testimony, I have provided statistical data which reflect the status of the Army's program.

It is evident that we have improved since 1978. We have included prevalency data, drug, and alcohol related offense data, discharge information and alcohol and drug abuse prevention and control program admission data.

We have also included data on law enforcement drug suppression efforts, which have played a significant role in our program.

The progress we are making in combating our problem is reflected in the data which show the percentages of service members who are returned to duty by our program, and by the fact that we have been able to contain the heroin abuse problem in Europe in spite of continually rising availability in that command.

During the last year we have opened an alcohol residential treatment facility at William Beaumont Army Medical Center, El Paso, Tex. Our future plans call for five additional facilities to be established beginning in fiscal year 1984.

Additional program initiatives call for the establishment of a management information system to assist us in analyzing data and evaluating our program.

We are looking into methods to improve identification to insure that we are not recruiting service members who demonstrate drug and alcohol dependence. Living and working conditions in Europe continue to be an item of major concern.

I want to assure this committee that the Army remains positively committed to prevention and control of the problems of alcohol and drug abuse.

We appreciate the interest and support of this committee and the emphasis you have placed upon the problems that are a constant concern of the Army staff and commanders throughout our system.

I would like to add here, if I may, the initiatives that we have taken since the 1978 hearings.

U.S. forces in the Federal Republic of Germany have worked together through the central working group to reduce availability of drugs in Germany.

In addition, the U.S. Army has increased law enforcement resources significantly in USAREUR. The Army has shortened tour lengths for single and unaccompanied personnel in USAREUR. We are working on continuing to improve the quality of life for our soldiers.

We have worked to upgrade the professional and paraprofessional staff in the program and improve the in-service training of our clinical personnel.

We have established a mobile training and technical assistance team. This team will travel down to installation level. They are people who are professionals. They will instruct, they will listen to the problems, and they will advise the installation staff.

We have established, as I said, a residential treatment facility at William Beaumont and we have provided USAREUR with 104 additional clinical personnel and are monitoring the quality of the personnel hired.

[The prepared statement of Major General Clarke follows:]

PREPARED STATEMENT OF MAJ. GEN. MARY E. CLARKE, DIRECTOR OF HUMAN RESOURCES DEVELOPMENT, OFFICE OF THE DEPUTY CHIEF OF STAFF FOR PERSONNEL, DEPARTMENT OF THE ARMY

Mr. Chairman and Members of the Committee, I am Major General Mary E. Clarke, Director of Human Resources Development, Office of the Deputy Chief of Staff for Personnel, Department of the Army. Accompanying me today is Mrs. Helen D. Gouin, Chief of Alcohol and Drug Policy, Office of the Deputy Chief of Staff for Personnel.

I appreciate the opportunity to appear before this committee and to address the programs and initiatives undertaken by the Army in our fight against alcohol and drug abuse.

We share a mutual concern for the effects of alcohol and drug abuse on combat readiness and I am confident that we are making progress in combating this complex problem.

The Army has continued its all out effort to prevent the abuse of alcohol and other drugs by soldier, civilian employees, family members, and retired military personnel. The Army Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) directly supports our commanders. It assists in reducing turbulence primarily through the rehabilitation of personnel in the military environment, where substance abuse surfaces, and by returning them to duty as soon as possible.

When rehabilitation fails, we eliminate the military member or civilian employee from government service in an expeditious manner.

EXTENT OF THE ALCOHOL AND DRUG PROBLEM IN THE ARMY

The following data show the admissions to the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) during the period 1978 to 1981. Case load admissions for alcohol have steadily increased from 56 percent of total to 75 percent during first half of 1981.

Type of drug	1978		1979		1980		January-June 1981	
	Admissions	Percent	Admissions	Percent	Admissions	Percent	Admissions	Percent
Alcohol	12,193	56	14,130	66	17,368	71	9,787	75
Other drugs	9,750	44	7,329	34	7,111	29	3,181	25
Total	21,943	100	21,459	100	24,479	100	12,968	100

We estimate that during the period 1978-1980, 65-70 percent of the personnel admitted have been successfully rehabilitated and returned to duty. Alcohol and other drug abuse prevalency data were obtained from the DOD Worldwide Survey of Nonmedical Drug Use and Alcohol Use Among Military Personnel: 1980, conducted during February to April 1980. The data obtained from this latest survey follows:

[In percent]

	Enlisted	Officer
Used cannabis at least once preceding 30 days	33.3	3.5
Used other drugs at least once preceding 30 days	11.6	.6
Exhibited alcohol dependency	9.4	.4

IDENTIFICATION STATISTICS

[ADAPCP admissions by case finding methods]

	1978		1979		1980		January-June 1981	
	Admissions	Percent	Admissions	Percent	Admissions	Percent	Admissions	Percent
Bio chem	2,493	11	1,964	9	1,985	8	765	6
Self-volunteer	6,286	29	6,654	31	7,614	31	4,106	32
Cdr/Sup	7,065	32	7,694	36	9,790	40	5,487	42
Law enforcement	4,662	21	3,782	18	3,863	16	1,976	15
Medical	1,437	7	1,355	6	1,227	5	634	5
Total	21,943	100	21,459	100	24,479	100	12,968	100

COMMANDER DIRECTED URINALYSIS

	1978	1979	1980	January-June 1981
Number persons tested	141,880	235,543	240,955	115,242
Number positives	5,619	6,524	6,984	2,184
Number confirmed	3,192	3,084	2,921	843
Percent confirmed of positives	57	47	42	39

NONJUDICIAL PUNISHMENT AND COURT-MARTIAL CONVICTIONS FOR DRUG RELATED OFFENSES

[Calendar years]

	1978	1979	1980	January–March 1981
Article 15	15,207	15,449	15,185	4,479
Summary court	149	275	464	128
Special court	714	811	937	307
General court	305	589	488	110

Discharges for drug and alcohol reasons

Year:	*Total*
Fiscal year 1978	3,349
Fiscal year 1979	3,784
Fiscal year 1980	2,863
Fiscal year 1981 (1st and 2d quarters)	1,519

LAW ENFORCEMENT DRUG SUPPRESSION EFFORTS

The primary tool used by Army law enforcement to combat the drug threat facing the Army is the Joint Drug Suppression Team (JDST). Currently, the Army employs 75 JDSTs, staffed with over 300 Military Police (MP) investigators, MPs, and Criminal Investigation Division (CID) special agents. These are responsible for the suppression of illicit drug trafficking directed toward Army affiliated personnel worldwide. Within the Continental United States (CONUS), these teams are basically decentralized, operating at the installation level.

Just under one-half of all Army assets dedicated to drug suppression are located in US Army Europe (USAREUR). The central activity, or heart, of the USAREUR drug suppression operation is the Drug Suppression Operations Center (DSOC). Established in November 1978, this activity is responsible to the Commander in Chief, USAREUR to manage and coordinate the entire USAREUR drug suppression effort, to require and approve community plans, to acquire, collate, analyze, and disseminate drug information and direct special drug suppression operations. The DSOC has proved to be an extremely successful tool in USAREUR's war on drugs. One augmentation that is unique to USAREUR is the Level I Drug Suppression Team (DST, which is composed of seven USACIDC special agents, who covertly target international drug traffickers that distribute illicit narcotics to US forces personnel in Europe. During calender year 1980, Level I activities (covert) resulted in the apprehension of 268 international drug traffickers.

During calender year 1980, Army drug suppression efforts worldwide were responsible for illicit drug seizures valued in excess of $137.5 million, while expending $595,271 in contingency funds. This equates to $230 worth of drugs seized for every $1 spent. Additionally, USACIDC was responsible for the apprehension of 6,607 drug offenders, 5,769 military, and 838 civilians.

The number of drug sale and trafficking cases in 1980 decreased 17 percent from the 1979 level of 3003. For the 1st QTR 81 there were 660 sale/trafficking cases, an increase of 5 percent over the 1980 quarterly average.

The number of marijuana use/possession cases in calendar year 1980 was 20,276, down slightly from the 20,711 in calendar year 1979. During the 1st QTR calendar year 1981, a total of 6,243 cases occurred which is a 17 percent increase over the corresponding period for calendar year 1980.

Law enforcement program results reached fruition in 1980, when there were decreases in both the drug sale/trafficking cases as well as the marijuana use/possession cases. These declines, especially in sale and trafficking, were generated by the Army emphasis begun in late 1978, along with increased numbers of law enforcement personnel committed to the effort.

The progress we are making in combating our problem is reflected in the data which show the percentages of service members who are returned to duty by our program, and by the fact that we have been able to contain the heroin abuse problem in Eurpoe, in spite of continually rising availability in that command.

During the last year we have opened an alcohol residential treatment facility at William Beaumont Army Medical Center, El Paso, Texas. Our future plans call for five additional facilities to be established beginning in fiscal year 1984.

Additional program initiatives call for the establishment of a Management Information System to assist us in analyzing data and evaluating our program. We are looking into methods to improve identification to ensure that we are not recruiting service memnbers who demonstrate drug and alcohol dependence. Living and working conditions in Europe continue to be an item of major concern.

I want to assure this committee that the Army remains positively committed to prevention and control of the problems of alcohol and drug abuse. We appreciate the interest and support of this committee and the emphasis you have placed upon the problems that are a constant concern of the Army staff and commanders throughout our system.

Mr. ZEFERETTI. Thank you, General Clarke.

Admiral Mulloy.

TESTIMONY OF REAR ADM. PAUL J. MULLOY, DIRECTOR, HUMAN RESOURCES MANAGEMENT DIVISION, OFFICE OF THE CHIEF OF NAVAL OPERATIONS, U.S. NAVY

Admiral MULLOY. Thank you, Mr. Chairman.

Thank you for allowing me to submit my prepared statement and I will try to summarize briefly what it contains.

First of all, I would like to say I am honored to be in this chamber of government.

Second, I am proud to be here in this uniform. I recently completed 6 years at sea where I was privileged to be in command of three major commands of our beautiful sailors and I detest, like you, the nemesis of drugs and what it is doing to our beautiful shipmates.

I also would like to say I know the Navy appreciates what this committee is doing to highlight that problem and solve it.

I think you will see that from some of the programs. I would like to summarize some of these items.

From fiscal year 1981 to fiscal year 1983 there will be a 58-percent growth in the money accorded to drug programs. There will be a 20-percent increase in people even though we are very short of petty officers who are the leaders that we really need for the attitude and behavioral changes. Even so we are going to do it.

Mr. ZEFERETTI. Thank you on behalf of all petty officers, such as myself.

Admiral MULLOY. Thank you. Our Naval Investigative Service investigations are up 36 percent this past year. There have been 4,029, which alludes to what the Drug Enforcement Administration was speaking of. The Navy drug safety action program was introduced at three sites in fiscal year 1981. We have 33 portable urinalysis kits now and will obtain 70 more in 1982.

We added nine law enforcement specialists in 1981 which are going to the commander in chief of our fleets and type commanders. Twenty-four drug dogs were added in fiscal year 1981. The total is 77 now, with more to come. Three officer billets will be added at the Washington headquarters level.

The Navy is going to the general quarters on this. We are waging a war on it. We recognize the problem. We have a particularly unique one because of the ships at sea.

Another thing that is important is a message that has been sent out to all hands by Admiral Hayward directing us to shift the rudders, get serious about this program, and get the front end to the detection, inspection, and enforcement squared away.

We are putting money and effort into that as well as increasing the moneys for treatment and rehabilitation. That message was also followed in June by a message from the Secretary of the Navy.

Then another message was sent from CNO to all commanders and commanding officers down to the basic units with a postscript in his own handwriting. He describes how deeply concerned about this problem he is and how he wants all to become personally involved.

I know the genuine concern is because of our beautiful people. I think my assignment, my position, which is only a little over a month old, as Director of Human Resources Management in the Navy Department reflects Admiral Hayward's interest in people programs.

Part of that care is to make sure something like drugs gets beaten.

We are appreciative of the help of this committee.

Mr. ZEFERETTI. Thank you, Admiral.

[The prepared statement of Rear Admiral Mulloy follows:]

PREPARED STATEMENT OF REAR ADM. PAUL J. MULLOY, DIRECTOR, HUMAN RESOURCES MANAGEMENT DIVISION, OFFICE OF THE CHIEF OF NAVAL OPERATIONS, USN

Mr. Chairman and Members of the Committee:

I. INTRODUCTION

I am Rear Admiral Paul J. Mulloy, currently serving on the staff of the Chief of Naval Operations as the Director, Human Resource Management Division. I am pleased to have this opportunity to address you concerning the Navy's programs in the area of drug abuse. I am working closely with each of the other services and the Department of Defense to ensure that the Navy continues to maintain and enhance the sound and workable drug abuse control program it has already established to combat this insidious and pervasive problem. Drug abuse is a major concern in the Navy today. Current data indicates that drug abuse among Navy people closely parallels that of our civilian counterparts. However, the mission of the Navy is critical to the defense of this country, and, for this reason, the Navy is totally intolerant of drug abuse. That means that all personnel who are involved in this illegal activity are immediately subjected to disciplinary action, or treatment, or both, depending on whatever is considered most appropriate and effective to eliminate such misbehavior.

II. BACKGROUND

The 1980 Department of Defense worldwide survey of nonmedical drug use and alcohol use among military personnel graphically documented the extent of the problem that the Navy has been formally combating since the late 1960's. The increasing trend of drug abuse in the Navy revealed by the DOD survey was subsequently confirmed by a Navy-directed surprise urinalysis of over 2000 Navy individuals. According to these surveys, the use of drugs among Navy people seems to be largely restricted to the lower five enlisted paygrades. There are, of course, some exceptions. For example, six percent of our senior enlisted members surveyed in paygrades E6 through E9 and two percent of our junior officers in the ranks of Lieutenant and below reported using cannabis during the preceding 30 days. The DOD survey also indicated that work impairment due to the use of drugs is most prevalent in the E-1 through E-5 population.

III. IMPACT OF DRUG ABUSE

The illigal use of drugs in the Navy and the adverse impact of drug abuse are cause for continuing concern. Commanding Officers at every level have a keen appreciation for the potentially harmful effects of drug abuse on operational readiness. Incidents of drug abuse are dealt with as serious threats to safety, security, and combat effectiveness. To aggressively counter such threats, the Navy has enhanced its drug abuse control program. Recent changes to governing directives issued by the Department of Defense and the office of the Secretary of the Navy have, additionally, strengthened this program.

IV. OBJECTIVE OF THE NAVY'S DRUG ABUSE CONTROL PROGRAM

The objective of the Navy's drug abuse control program is prevention and control of drug abuse through positive and visible leadership and action throughout the chain of command. Commanding Officers and supervisors at all levels will not condone the illegal use of drugs—regardless of the degree of acceptance in the civilian sector. Commanding Officers have been directed to convey a consistently tough intolerance to drug abuse that will be understood clearly by all hands. Officers and petty officers have been trained to recognize the threat, set the example, enforce the rules and work to change conditions, both at sea and ashore, to eliminate illegal drug use.

V. TOOLS AVAILABLE FOR COMBATING DRUG ABUSE

Aggressive use of all the tools available to us is essential to truly effective prevention and control. Such tools include prevention education, awareness training, law enforcement services, command drug assessment team services, urinalysis, drug detector dogs, and, when deemed appropriate, punishment under the Uniform Code of Military Justice. We have learned from past experience that early intervention is essential once a drug abuser is identified. Rehabilitative or punitive measures, as appropriate, must be quickly initiated so that the member may be returned to duty or discharged promptly.

VI. THREE LEVELS OF REHABILITATION

To accomplish this, three different levels of rehabilitation are provided to those identified as drug abusers. First, local command level counseling and retraining is provided with professional assistance from specially trained personnel assigned to our 66 Counseling and Assistance Centers located worldwide. The second level of rehabilitation consists of extended non-residental care under the direct cognizance of the trained drug abuse counselors at the Centers I just named. In Fiscal Year 1980, they screened approximately 12,000 members with drug abuse problems. The third level of treatment is provided by the Navy's Drug Rehabilitation Center in San Diego, where full-time residential care is administered to those who are diagnosed as drug dependent.

VII. DESCRIPTION OF THE NAVAL DRUG REHABILITATION CENTER

This unique facility has 180 beds to accommodate the inpatients in a seven-days-a-week program directed by a dedicated staff of military and civilian professionals who are highly skilled in all facets of drug abuse treatment. In addition to providing detoxification therapy, the Center also functions as the final screening and evaluation point for maladaptors who are being separated for drug as well as other misconduct related problems. Other valuable services provided by this organization include the on-site training of drug abuse counselors and providing quality control monitoring and inspections for our worldwide network of Counseling and Assistance Centers. As the central collection agency for all information dealing with drug abuse, the Center maintains an extensive data base for ongoing statistical research and analysis.

VIII. SEEKING THE SOLUTION TO THE NAVY'S DRUG ABUSE PROBLEM

The solution to the Navy's drug abuse problem is being sought through a concerted Navywide effort. Thousands of dedicated people, ranging from high-level staff specialists to those working on the waterfront, are constantly trying to find the right course of action which will convince abusers to stop using drugs. All our courses for Prospective Commanding Officers include discussions on the subject of drug and alcohol abuse policies and programs. One of our most successful counterattacks to drug abuse is the current resurgence of pride and professionalism being felt throughout the fleet today. This return to proven leadership techniques is resulting in new initiatives which achieve a better balance between necessary rehabilitation—and strengthened law enforcement and prevention. In order to accelerate dissemination of new policies prior to the routine publishing of recently revised directives, several messages have been released by the Chief of Naval Operations that highlight such matters as urinalysis testing for cannabis and new regulations governing drug abuse paraphernalia.

IX. NEW INITIATIVES

To assist our Commanding Officers in their efforts to deal with this problem and to further improve our total-force drug abuse control program, several new initiatives have been approved.

Newer and better portable urinalysis equipment is being purchased. These new suitcase-size kits are now being made available for fleet use following recently completed DOD-sponsored field testing by the Navy. This equipment, which can now also be used to test for cannabis, will significantly improve our ability to detect and deter the illegal use of drugs in an operational environment.

Additional drug detector dogs are being addded to the current inventory. Another 50 dog and handler teams will greatly improve our field detection capabilities and will double the Navy's effort in this area.

The assignment of Limited Duty Officer and Warrant Officer Law Enforcement Specialists to major fleet and type commander staffs has been accelerated. This will provide additional expertise to effectively administer all law enforcement aspects of an aggressive drug enforcement program.

A first echelon inspection and assistance team of three experienced officers is now being established at the Washington Headquarters level. This team will provide vital feedback information for more rapidly and directly assessing the nature of the problem and the effectiveness of the entire drug abuse control program.

The Navy's Drug Safety Action Program, patterned after the highly successful Alcohol Safety Action Program, has been developed for remedial education of identified drug abusers. Implementation of this 36-hour education and motivation program is aimed at overcoming the adverse impact of drug abuse by instilling more positive attitudes and goals in our Navy people.

New regulations prohibiting the use, possession, sale, or transfer of drug abuse paraphernalia are given the force of general orders, upon which disciplinary or punitive action may be based. Violation of these new regulations on paraphernalia will constitute a violation of the Uniform Code of Military Justice.

When probable cause exists to believe that evidence of a crime will be found, the results of urinalysis tests, when confirmed as positive for drug use by a shore-based laboratory, may now be used as evidence in non-judicial proceedings or possibly in trials by courts-martial.

X. LONG-TERM INITIATIVES

We have also initiated long-term actions in other areas.

Two master-at-arms mobile training teams are planned, one on the East Coast and one on the West Coast, to provide technical assistance visits and classes in implementing effective drug enforcement programs afloat.

We plan to expand the date base for the Navy Alcohol and Drug Information System to include more information on law enforcement and more detailed statistical profiles of the typical drug abuser. This will assist us in analyzing the extent of our problem and improve our ability to adjust the management of our programs accordingly.

Also in planning for fiscal year 1983 is the addition of nine officer billets on the major headquarters' staffs throughout the fleet. These officers will be specifically assigned to advise the fleet commanders on all matters pertaining to the Navy's drug—and alcohol— abuse control programs.

XI. THE DESTRUCTIVE EFFECTS OF DRUG ABUSE

We in the Navy realize that drug abuse is destructive of our efforts to instill pride and promote professionalism. It is costly in terms of lost manhours, unnecessary administrative and judicial processing, and a critical drawdown on morale and esprit-de-corps. We know that it is not only the drug abuser who is affected, but also the abuser's shipmates as well. This is because those who are involved in drug abuse frequently demonstrate a serious lack of discipline and a willful shirking of duties, which can create a dangerously contagious feeling of distrust and suspicion in a ship's crew. Inevitably, other more impressionable individuals may be enticed to join in the abuse of drugs because of the very real force of peer pressure.

XII. ALTERNATIVES TO DRUG ABUSE

Drug abuse is very often symptomatic of deeper psychological or social problems. Therefore, in addition to dealing with or treating the immediate problem, the Navy is striving to offer broader philosophies of living that support and encourage the option *not* to use drugs. The fostering of this attitude is a principal responsibility of every leader at every level in the chain of command and is purposely woven into our courses on preventive education, counseling, rehabilitation and our leadership skill training.

XIII. SUMMARY

In summary, the Navy's goals for the years ahead are to improve the law enforcement approach to combating drug abuse, to improve the utility of urinalysis detection through wider distribution of the new portable equipment, and to improve our ability to discourage our people from using drugs in the first place. We are trying hard to make drug abuse less of a seemingly glamorous and acceptable escape from the hardships often experienced by those who serve at sea. We are also doing our best to make drugs themselves less readily available to our people both ashore and afloat. We know that if we are to be successful in eradicating this debilitating problem, we will need the uncompromising support of the national news media, the Congress, and the people of this great nation.

I welcome your questions.

TESTIMONY OF BRIG. GEN. ANTHONY LUKEMAN, DIRECTOR, PLANS AND POLICY DIVISION, MANPOWER DEPARTMENT, HEADQUARTERS, U.S. MARINE CORPS

General LUKEMAN. Good afternoon, sir. Thank you for the opportunity to put my formal statement in the record and make these informal remarks.

I would simply like to reaffirm our absolute commitment to licking this problem and attacking it from every possible direction.

Drug abuse has individual and organizational implications that are absolutely unacceptable. Part of the problem is one of changing values. Many of today's young people are more self-centered, less interested than members of the committee are and I am in those things that have to be done to preserve a free society.

As members of this select committee have pointed out extremely clearly, the military services should be able to change that to a great degree for our people.

We try to build on the natural desire of our young men and women to belong and to shift the attitudes from going along with something because it is comfortable or because it feels good, to putting their talents to work for their squad or section, the lowest Marine unit.

We consider every marine who abuses drugs to be no less of a concern than a marine who is wounded on the battlefield. We have got to get marines down to the lowest level thinking the same way.

That is the primary objective. To the extent that we can accomplish that, then all the rest of it, the evaluation, the counseling, the treatment, the disciplinary action, will follow.

Thank you, sir.

[The prepared statement of Brigadier General Lukeman follows:]

PREPARED STATEMENT OF BRIG. GEN. ANTHONY LUKEMAN, U.S. MARINE CORPS, DIRECTOR, MANPOWER PLANS AND POLICY DIVISION

Mr. Chairman, Members of the Committee, I welcome this opportunity to appear before you today and explain the programs and initiatives undertaken by the Marine Corps to combat drug and alcohol abuse among Marines. We consider the threat of drug and alcohol abuse to be equivalent to an enemy weapon that can wound Marines and affect our ability to fight. That threat requires—and receives—the attention of leaders, who have the ability to change attitudes through example. Marines have traditionally taken care of their own, and we continue to work hard to let our Marines know that drug and alcohol abuse is everyone's responsibility. The Marine Corps is attempting to influence the overwhelming majority of good Marines to apply peer pressure to those who abuse drugs or alcohol and let them know such actions will not be tolerated. Difficult to accomplish—and it takes time—but it must be done. That said, allow me to explain our programs and initiatives.

The Marine Corps' drug and alcohol programs are conducted by field commanders using guidance provided by Marine Corps Headquarters. Drug and alcohol representatives are in each Marine unit down to the battalion/squadron level. An aggressive effort of early identification, precise evaluation, timely referral, proper treatment and rehabilitation, and quality education are continuously pursued. I would like to highlight some of these areas for you.

We have been vigorous in our efforts to identify and refer to treatment drug and alcohol abusers. In fiscal year 1980 approximately 7,300 instances of drug abuse and 10,100 instances of alcohol abuse were identified through our formal reporting procedures. The majority of these instances were uncovered by military law enforcement personnel. Others were uncovered by command referral, personal admission, civil law enforcement, medical examinations and urinalysis.

The Marine Corps actively uses the urinalysis testing method of identification, and in fiscal year 1980 conducted some 62,000 commander-directed tests. This occurred when the Corps was at an average strength of 188,000. Urine samples are sent to Department of Defense drug testing laboratories for determination of the presence of drugs. The laboratory conducts two different tests for those samples found to contain a drug. These results are then returned to the field commanders who must confirm whether an individual was using an illegal drug, or was taking prescribed medication. Currently, sixty eight percent of the Marines who are identified as positive by laboratories are subsequently confirmed as drug users by their commands.

Once identified as a drug or alcohol abuser, and depending on the individual circumstances, Marines are disciplined and/or screened and referred for local or formal treatment as necessary. Local treatment and rehabilitation programs are established at every major command. Program objectives are to establish within the individual a sense of personal worth, to motivate the individual toward seeking a productive drug/alcohol free life, and to instill into the individual a personal goal of returning to full productive service in the Marine Corps. Marines requiring treatment and rehabilitative services beyond the capability of local commands use U.S. Navy treatment facilities. Marine counselors are integral members of the professional staffs at ten of these facilities.

If a Marine is determined to be drug dependent he must have potential for further service before assignment to the Navy Drug Rehabilitation Center. Those drug dependent Marines without potential are entered into a 30-day local treatment program and discharged. Treatment at a Veteran's Administration Medical Center is possible in conjunction with discharge if the Marine so requests.

One of the primary tools in combating drug and alcohol abuse is education. The Marine Corps education programs provide objective knowledge and factual information for all Marines. Basic education concerns the individual's personal values, techniques of solving problems, and help in making difficult personal decisions. Education for supervisors provides an insight into identification of and confrontation with drug and alcohol abusers, a knowledge of referral procedures, programs for treatment and rehabilitation, and command perspectives on drug and alcohol abuse problems. Over 200 senior officers and sergeants-major attend a special leadership and substance abuse awareness course each year. This one-week course gives an awareness and better understanding of the physiological and psychological aspects of substance abuse to those who can directly influence Marines the most: commanding officers, executive officers and sergeants-major. For those junior officers and noncommissioned officers assigned drug and alcohol duties at the unit level, where personnel turbulence is the greatest, a substance abuse information course is given three times per year at the larger Marine installations. The main purpose of these education programs is to keep Marines informed about the dangers of drug and alcohol abuse.

The Department of Defense drug and alcohol use survey released last year made us more aware of the size of the problem and led to increased efforts to attack it. Several new initiatives have been taken or are ongoing at this time, which I'll highlight now.

Funds have been made available to purchase enough portable urinalysis kits and reagents to conduct a one year test beginning 1 October 1981. These kits will be located at major Marine Corps locations in the continental United States, Hawaii and Okinawa. Enough reagents have been purchased to conduct approximately 270 drug tests per month per kit location, with marijuana being the primary drug for which urine samples will be tested. The portable urinalysis kit will allow immediate identification of suspected drug users.

The new Secretary of the Navy Instruction 5300.28 prohibiting the use, possession, sale or transfer of drug abuse paraphernalia is given the force of a general order upon which disciplinary or punitive may be based. The Marine Corps participated in developing this instruction and welcomes its addition to the directives supporting our efforts to reduce the instances of abuse.

In the area of education and awareness, we are examining different types of presentations by knowledgeable professionals in the field particularly targeted to the majority of our Marines who are in the vulnerable target-age of 18-25. For those Marines working in the law enforcement and drug/alcohol fields, specialized training to recognize, manage and prevent phencyclidine abuse is being developed.

The Department of Defense survey showed a significant difference between the United States Air Force and the rest of the services in instances of drug and alcohol use. Consequently, the Marine Corps is currently reviewing the Air Force drug and alcohol program to see if our policies and procedures might be modified in areas where similar problems seem to exist in the two Services. Some additional initiatives are anticipated as a result of this study.

The Marine Corps shares the national awareness of drug and alcohol abuse and is determined that such abuse will be identified and that abusers will be helped where possible and disciplined where necessary. Sometimes the answer is both: knowing that abuse will lead to disciplinary action is one aspect of assisting individuals to make the sensible decision to refrain from abusing. Every effort is made by the Marine Corps to rehabilitate those who can be helped and return them to their commands as productive Marines capable of performing their primary jobs. Those that cannot be helped are discharged. The problem requires the knowledge and constant awareness of leaders, whose foremost concern is the well-being of their men: leaders who recognize that success in every effort depends on the morale, discipline and ability of those men. Our objective is to show individuals that our values must be theirs. Most rise to that challenge. Some take longer than others. A few can't adjust. We will continue this vitally important effort and are deeply grateful to this committe for its continuing concern and assistance.

Mr. ZEFERETTI. General, did you want to say something?

General LEWIS. No, sir.

Mr. ZEFERETTI. Thank you. One of the things the press brought to us, they want to know why our figures indicated that the Air Force had such a low level compared to the other services, and you could make all kinds of speculation on that one, but one of the things I would like to ask you in relationship to that is that if, in fact, the Air Force figures were accurate—and we have every reason to believe that they are—is it a question that they have a program that they are not sharing with the rest of you? Or is it something that is a phenomena all by itself?

What I am trying to get at, do you share either the successes or the failures of the individual programs that you might put into effect? Do you share the information that comes out of a kind of training concept that you might put into effect?

Do you share the effort of the kind of training that might go into the NCO's, the petty officers, for the ability to recognize and administer treatment at an early stage?

The bottom line is, do you share any of this intelligence between you or are you working as an entity unto yourselves, treating it as something that the Marines have to worry about, something that the Navy has to worry about?

It is an Armed Forces problem, a national defense problem. I would like somebody to address that kind of concern.

General LOUISELL. I will start off, Mr. Chairman, if I may.

In answer to the question do we share, we certainly do. We share in the area of assessment, treatment, education and training, and detection and deterrence.

But first some of the differences between services. It is recognized in the field that there are at least four determinants to drug prevalence. They have to do with age, the number of women in a given sample, marital status, and educational level. Those are four universal criteria that tend to make prevalence vary.

It happens that the Air Force is the oldest service. Their average age is 26. They are the most married service. They have the largest number of women. Overall, the prevalance rates from women are much lower than prevalence rates for men. When you add a large number of women to a sample, the prevalence rates come down. The Air Force, at the present time, has the highest educational levels of the four services.

There are two other factors that I think are peculiar to the military environment.

One of them is what I would call mission or environment. That is, with all due respect to some Air Force people who have some very tough, dirty, and unpleasant jobs continually; in general, the enlisted men and women of the Air Force live in what you might call an industrial environment.

They work in maintenance shops, administrative shops, communications shops, electronic shops, and do shift work that is reasonably predictable as to its levels of intensity, duration, regularity. That helps.

You take the other end of the scale, and I would say that would probably be the Marine Corps. They not only operate in an environment similar to the Army in that they are in the field training day by day, week by week; they also deploy as the Navy does, so they get the worst of both worlds. The Marine Corps mission environment is highly stressful and would lead you to believe that that is going to be a factor you ought to consider in identifying differences between service prevalence rates.

The last but not least, are the programmatic differences. There are differences. I think the four services have at least implied that there are differences. They are working on some of those differences that need improvement.

In the terms of sharing, at least at the Department of Defense level, we have an annual conference every year for all four services. We invite their professionals, paraprofessionals, and commanders, about 150 to 200 people, expose them to the cross-pollination process.

In the treatment area, the Navy treatment facility in Okinawa has handled members of all four services and the Army has handled Air Force personnel in Europe. There is a cross-pollination of the use of facilities. It is not as good as we should have, but we are working on that and getting better.

Mr. Zeferetti. General, the program part of that, is that shared also? A program that may be an effective one, one that you get results from?

General Louisell. Also at the DOD level, we have a DOD advisory committee which consists of representatives of the services, these gentlemen or their representatives. Every policy development that is made, at least at the Department of Defense and most of the time internal to the services, is discussed and criticized at the advisory committee meetings.

Those are some of the DOD forums in which this cross-pollination occurs. The same thing occurs in law enforcement. In the Philippines, for instance, where you have two services that are away from the continental United States, the law enforcement efforts there are coordinated. They are also coordinated in Europe between the Air Force and the Army. So at the local level, at the departmental level, and at the staff level programs are coordinated.

I would pass to the service representatives here for their views on how it works and whether it is useful.

Mr. ZEFERETTI. Let me just give you a question.

Maybe you can tell me how each of you would handle it.

Suppose you identified a substance user. Who makes the decision where to refer him or her for treatment or for criminal prosecution? How do you do it in the Air Force versus the Navy versus the Army or Marines?

Do you all do it the same way? Do you have a different procedure to follow for that individual user?

General USHER. If I can start off, of course, there might be differences in minor detail between the services, but I think we all approach it pretty much the same way.

First of all, we try to evaluate the situation and evaluate the individual. Again, as we alluded to earlier this morning, it depends in part on whether it is a first time offense, by an immature individual. However, that evaluation takes the collective judgment of the commander, the first sergeant, and professional help, medical, chaplain, JAG, and law enforcement people, to give the commander a comprehensive view of what is involved.

Then our regulations permit us to treat a first-time drug abuse incident as a serious disciplinary problem.

We react accordingly by punishing the individual, putting him back to work and maintaining surveillance on him. If it looks like it is more of a rehabilitation problem for a confirmed drug abuser who is worthy of rehabilitation, that might be another route to go. Indeed if this is a repeat offender and there isn't a reasonable probability to believe rehabilitation is warranted, then appropriate separation action is initiated.

It is best done by that local commander in concert with his expert help on that installation because we believe that the keystone to our success is giving the commander both the responsibility and the authority to handle these problems.

Mr. ZEFERETTI. What my colleague, Mr. English, was talking about earlier in his statement and in his questioning of the general was that he was concerned with the objectivity of the Navy commander.

General USHER. I understand the point, Mr. Chairman. Again I allude, first of all, to the list of experts I mentioned that are called for expert advice in our drug and alcohol control regulations. This in and of itself tends to mitigate any kind of bias that was alluded to there.

The other thing is, we have a lot of experience with appointing commanders, and integrity is very, very high on our list.

I think I would have to say sure, we make mistakes every once in a while. The vast, vast majority of our people couldn't afford to allow themselves to operate in such a biased way. I don't think it happens with any degree of regularity.

Mr. ZEFERETTI. Do you all share the same feeling that at that level it is the best way to go forward?

Is there a followup that you do on the individual? For argument's sake, if you have someone that you identify, you put him through a treatment process, and it works and if the young man or young lady comes out and they are OK, is there a monitoring or followup of the individual to make sure that that individual is given some further counseling or whatever it might be that might come along?

General USHER. There is followup. As a matter of fact, we try to keep track of our recidivism rates where we find that people fall back into the habit again in one way or the other.

Of course, it is true that once an offender—the chances are higher that that person will become an offender again.

Mr. ZEFERETTI. Do you make a difference between one that is caught using a substance on duty versus somebody that is caught using drugs off duty?

Do you make a difference as to amount of severity of what you are going to do, because he was on duty at the time?

Do you make an evaluation that way?

General USHER. It is hard to speculate in the general sense of the word.

Obviously we are very, very much concerned about any use on duty. We are also concerned about any use off duty, particularly, you know, in the barracks or something like that.

So it is very difficult to sort of sit here and say that, well, as a general rule we treat that more severely. Again you have to look at the specific circumstances.

Mr. ZEFERETTI. What you are saying is, each individual is looked at as an individual case?

General USHER. That is what we try to do.

Mr. ZEFERETTI. You adjudicate whatever the evidence shows for that particular individual?

Thank you.

Mr. English?

Mr. ENGLISH. Thank you very much, Mr. Chairman.

General Louisell, I don't want to beat a dead horse, so to speak, but, getting back to this issue with regard to tolerance of drug abuse, how much can we accept, what is acceptable?

I think you probably agree with me none is acceptable if we are going to talk in the purest terms.

But, ideally speaking, we don't have that perfect world which I think we would all like to see, but I do think perhaps we can set some goals that we can expect to be met.

Now, the Air Force has a rather comprehensive record as far as the drug abuse situation when compared to the other services, at least as far as our survey is concerned, and every survey I have ever seen.

You have given us the reasons that you think this is the case and you stated that the Marines, for instance, are similar to the Army.

Looking at the items you were mentioning, the enclosures, you are talking about quality of life factors, the place the guy has to work, what kind of circumstances he is working under. He may be slightly older and more mature. Granted, that is a big factor.

It may be the fact that he is married and more settled. That is a factor.

Looking at the statistics on age, we ended up with the Marines, I think, that had the youngest group. Statistically it was the youngest group that we had. When we look at this critical issue—and I think it is a critical issue of on duty use—the Air Force was first, but second came the Marines.

It seems to me—in fact, what we are looking at, and I think it is commendable, 93 percent of the Air Force said that use took place off duty, not on duty, but off duty.

In fact, we had none that said it was used solely on duty.

The Marines had 76 percent that said use was taking place solely off duty.

The Navy, 57; the Army, 60.

Would you say that it is fair for us to get the level of, let's say, the Marines on duty use of drugs as being a fair measure as what we can expect out of the Army and the Navy?

Quite frankly, I am tempted to say the Air Force, but we have a set of criteria there that may be more difficult to meet.

General LOUISELL. Well, you can tell by my long pause I am reluctant to set criteria. I nor my office has really looked at the proposition of what is a realistic expectation in the reduction.

Mr. ENGLISH. I am just talking about——

General LOUISELL. And I think it is proper to ask when can we start getting satisfied?

I personally would like to stay in a state of dissatisfaction about drug and alcohol abuse until it gets to zero.

Otherwise we will not run hard enough.

In terms of comparing the services and using one as a benchmark, or as a goal, I am a little reluctant to do that because the nature of the sample from which you are drawing your comparisons. Frankly, I think the sample you took in Naples was a particularly outstanding unit. It may not represent the average, across the board.

Mr. ENGLISH. Are you telling me that you think other Marine units would be worse than the sample that we got or other locations around the country?

General LOUISELL. Our figures in the DOD survey are different from what we are talking about. My point is, I don't think holding one service up against another is going to be very satisfactory from the service point of view, nor is it in consonance with the reality of the nature of their service.

Mr. ENGLISH. Let me stop you right there. What we are talking about is what is realistic, what we can expect.

Now, the Air Force has done it. We are not even asking you to measure the other services and the amount of drug abuse that we got against the best. We are saying what about measuring them against the second best?

That seems to me to be very fair. The Marine Corps, as we have stated, at least in the sampling that we had, had the youngest group. Theoretically they have the people who are living under the least pleasant circumstances, at least that has always been the image. So the quality of life factors in dealing with the Marines should be more difficult than it is for the Army or the Navy.

All we are asking is, let's get a target, something that is reasonable, something we can deal with.

In this particular case we are talking about on duty use. That seems to me to be the very bottom line. For goodness sake, we ought to be able to do something about the drugs that are being used on duty. That ought to be a beginning. Certainly not an end. I am troubled.

I am genuinely troubled that you would be reluctant to say as far as on-duty use, we are not going to tolerate it.

The sample that we ran as far as the Air Force, we didn't come up with a single person who said that they used drugs solely on duty.

We did on some of the other services.

This is something that we ought to be able to zero in on and hammer on. It ought to be a focal point, something that the U.S. military simply will not tolerate is drug abuse on duty, period, and move on from there.

General Louisell. We have already said that, sir.

We have already said that loud and clear. Everybody knows it.

Mr. English. What are we going to do about it?

General Louisell. If you are looking for when do we reach a threshold of tolerance for the prevalences that we find in subsequent surveys; it will be when the Secretaries of the Air Force, Navy, and Army turn and say, "We are satisfied," then DOD will be satisfied.

Those are the thresholds that we can establish.

Mr. English. Is this level, the Marine Corps level of on-duty use, is that fair? Isn't that a fair measure?

General Louisell. No, sir, it is too high.

Mr. English. Is it a fair measure then as far as a target for the other two services to come down to?

General Louisell. I think they ought to be competing to see if they can get to zero.

Mr. English. I agree with you there, but is it a fair target? Is it too ambitious?

General Louisell. It is unacceptable——

Mr. English. Is it too ambitious, General?

General Louisell. Too ambitious? No, sir, it is not too ambitious. It undershoots the mark.

Mr. English. We can expect in a year or two that neither the Army nor the Navy will be higher in on-duty drug usage than the Marines? Is that correct? Can we expect that?

General Louisell. I think we can expect all four services to go as hard as they can, to get as close to zero, as soon as they can.

Mr. English. Also, we got into this issue of cannabis. We keep talking and separating out alcohol abuse; that is the big problem in the services. This is what you keep focusing on. Drug abuse is second.

But of the people that we surveyed, we found that over three-fourths, over 75 percent said that they combined alcohol with drugs.

Isn't it just quite likely, General, that what you have been focusing on as solely an alcohol problem is in fact a polydrug use problem?

General **Louisell**. Sparating the alcohol problem from the cannabis is not possible. You are correct; it is a polydrug problem.

The young 18- to 25-year-old substance abuser is a chemical gourmet. He will take anything he can get his hands on, whatever is available, whatever is being used in that particular peer group at the moment.

The point I made in my opening statement is that alcohol is the drug of choice of older people. In order to validate in the minds of the 18- to 25-year-old youngster that a drug abuse prevention program is necessary and essential, we must have an effective alcohol abuse prevention program that goes along with it——

Mr. **English**. Wouldn't it be——

General **Louisell** [continuing]. To give it credibility.

Mr. **English**. Wouldn't it be more accurate rather than saying alcohol is our No. 1 problem, to say polydrug use is our No. 1 problem?

General **Louisell**. Yes, sir, it certainly would.

Mr. **English**. As I have said, I already have thrown bouquets to the Air Force. I think particularly the on-duty results we got are outstanding.

I am pleased with that. Very happy with it.

The Army has made excellent improvements as far as hard drug usage is concerned. We still have a ways to go. I don't think there is any question about it.

I think you would agree. I think it is really quite amazing in the last couple of years that we have seen in some cases the rate cut as much as 50 percent over where we were a couple or 3 years ago.

We were still quite concerned about that.

Let me say as far as the Navy, they are kind of taking their licks, I think, as far as this particular survey is concerned. I think it should be pointed out, particularly as far as the *Forrestal* is concerned, that that particular carrier had been on duty for 60 some odd days and they had been involved in some very difficult times as far as long hours.

There was no way to reflect this in the survey results, but in the discussions that we had with the sailors who took the survey, we did find that the amphetamine usage as opposed to being the recreational type of drug usage that we have had in the past, was being used as a stimulant to help keep those people alert during those exercises.

I think that it is also worth noting and looking at the results as to the perception of the NCO's.

In many cases, particularly as far as hard drug usage and availability was concerned, the NCO's did not have a very good perception.

In the Navy, with the use of amphetamines, they did. The NCO's had a very accurate perception; almost identical to what the junior enlisted personnel were saying which I think again points out that they were fully aware that this is being done.

I am not saying that we condone it, but I think that we have to place that in a little bit different category than a recreational user, a guy just out here doing it for the heck of it.

I think they are using those pills because of the long hours and the strain. I think this is something that the Navy may want to take a look at, if there is any way to relieve that.

The Marines. As I have stated, I think that the Marines certainly do deserve some credit, given the age of the soldiers that they have, the people that they have to work with.

Certainly they are exposed to the same amount of drugs as, say, the Navy. We do find that the usage among the Marines is less, and, in particular again, as it was with the Air Force, the on-duty usage, and I think that this is something worth noting.

I don't think that we can use the excuse and say, well, that the Air Force has got an older type of soldier; he may be better educated, so on and so forth.

I think the Marines are a prime example that it is possible to have rates much lower than what we have now and that what we have now is not acceptable.

In general, I don't think there is any question that we should be able to make significant improvements and significant improvements rapidly if we had the type of attention paid to it that the Department of Defense should be paying to it.

I think they ought to put the kind of emphasis on it that needs to be placed on it.

I was on a program this morning with a young man who has recently come out of the service. It was interesting to note that even though he had been a former user, and using heroin, and had been in a very sensitive position, very sensitive job, his number one recommendation as to how to deal with the drug problem was to have a much more strict enforcement of military regulations.

Thank you, Mr. Chairman.

Mr. **Zeferetti**. Thank you, Mr. English.

Mr. Addabbo?

Mr. **Addabbo**. Thank you, Mr. Chairman.

Early in the questioning Mr. English asked DEA as to the amount or availability of drugs. They were very unsure, but the Army reported last year that they had seized over 2 tons of marihuana.

The Air Force seized only about a quarter of that amount.

The Navy and the Marines, where we find a large problem, don't even have any reports or records of drugs seized. What concerns me is in this recordkeeping. Again I join with my colleague, Mr. English, in commending those that show these low percentages of abuse, but I am wondering whether officers are keeping records and whether in some cases when men or women are found to be using drugs, whether they are always reported or whether they are covered up. In our hearing back in June, General Louisell mentioned the social acceptance. This pervades throughout the services, that there is a social acceptance of the use of marihuana, so therefore they don't actually have to report abuse. They don't have to do anything.

Has that changed, General, in any of your officers?

General LOUISELL. I am sorry, sir, I don't remember my reference to using that as a rationale for why it might be. I would have to look at the record. I don't remember it.

But from my own perspective I have great confidence in the accuracy and in the integrity of those who make reports. I do not mean that they don't make mistakes and I do not mean that the normal bureaucratic process doesn't lose data or pervert the data. That happens.

But, in terms of a malevolent intent, General Usher earlier on this morning hit it right on the head. We are not awfully bad at selecting commanders; and high on the list of selection criteria is integrity.

The services have made mistakes in that area, just like every other human institution has, but in the main we have tough minded people out there, honestly trying to do the job the best way they know how.

That includes reporting accurately the circumstances in their units.

Mr. ADDABBO. I mentioned in my opening remarks the question of the crash of the A-7 aboard the *Kitty Hawk* and the crash of the helicopter where personnel were lost.

Do you know, General, whether or not a request for a medical survey had been made to determine whether or not drugs were present in any of those crashes?

General LOUISELL. That concerns the U.S.S. *Kitty Hawk,* sir?

Mr. ADDABBO. Yes.

Admiral MULLOY. Mr. Chairman, it is now part of our procedures that in all aircraft mishaps in which a fatality is involved, part of the autopsy will include testing of all body fluids and also an analysis to look for drugs. That is mandatory.

In the *Kitty Hawk* incident that you mentioned, I happen to know they took urinalysis samples of all sorts of people that may have been involved, or in any position of influence.

I think the signal is loud and clear. The problem with the *Kitty Hawk* is that the kit malfunctioned so the results are in the mail to the laboratory. The signal is out there. They are getting serious. They are going about attacking the problem.

Mr. ADDABBO. Have you received the medical reports back?

Admiral MULLOY. No, sir, not from the *Kitty Hawk.* That was about a week ago.

Mr. ADDABBO. Will you supply my committee and this committee with copies of the reports when they are available?

Admiral MULLOY. Yes.

Mr. ADDABBO. Early in my remarks I said we often have heard the same scenario every time the military appears before the committees, especially my Committee on Defense Appropriations.

The justification for the millions of dollars they ask for these programs is "We are doing something about it and we will correct it," et cetera.

We heard that same statement here today. Let me read you a remark in the prior testimony.

> Let me reiterate that we in the Department of Defense do think that we have a serious problem and we are doing and will continue to do everything we possibly can to minimize the problem of drug abuse.

I think we heard a variation, but again similar statements were made today. This statement was made by former Deputy Secretary of Defense Charles Duncan back in July of 1978. It was made at hearings held by this committee.

At that time Secretary Duncan listed 12 initiatives with target dates and how he is going to correct these things. He listed 12 initiatives and he was going to correct these items.

I will submit them for the record. I want you to expand on them for the record, as to what has been done.

Design a comprehensive personal drug survey, initial target date May 21, 1979; use epidemiological data to assess drug abuse, extent, and location, target date March 31, 1979; modify drug and alcohol reporting systems to gather more uniform trend data, initial target date December 31, 1978.

Of these 12 items, every one of them had a target date of 1978 or 1979. We now hear of 12 new items that the Navy is now going to start.

Have you ever, do you know, General—and I ask you to expand for the record—whether any of these target dates were ever accomplished?

General LOUISELL. Sir, the Deputy Secretary of Defense, Mr. Carlucci, provided Mr. English a report, a complete report and an update in some detail on the 12 points that you are discussing.

I would like to submit those for the record now, if I may.

[The documents referred to follow:]

Question. What has been done to accomplish the twelve initiatives listed by Secretary Duncan?

Answer. Mr. Frank Carlucci, Deputy Secretary of Defense, provided on May 13, 1981 a complete accounting of the progress on the initiatives to Mr. Glenn English, the Chief of the Military Task Force of the House Select Committee on Narcotics. A copy of that response is attached.

THE SECRETARY OF DEFENSE,
Washington, D.C., May 13, 1981.

Hon. GLENN ENGLISH,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN: As promised in the interim reply to you from my Assistant Secretary of Defense for Health Affairs, I am forwarding the information you requested regarding drug abuse in the Armed Forces. I hope that you will find the information on the progress made in implementing Mr. Duncan's 12 initiatives useful (enclosure 1). Although some of these activities have been completed or overtaken by events, the remaining programs are, and will remain, on-going initiatives. We will, of course, implement new policies and activities as the need arises.

I have also included a summary of our more significant new activities at enclosure 2, and a comprehensive overview of the military services' actions to improve their drug abuse programs in Europe at enclosure 3. The update of the services' activities you requested is attached at enclosure 4.

I believe that the attached information will provide you with the facts you need on our drug and alcohol abuse control programs. I appreciate your interest, and thank you for your assistance in reducing drug abuse in the military.

Sincerely,

FRANK C. CARLUCCI,
Deputy Secretary of Defense.

Enclosures.

ACTIONS TAKEN TO ACCOMPLISH THE DEPUTY SECRETARY OF DEFENSE 12-POINT PROGRAM OF JULY 27, 1978

The following discussion describes the events and actions taken to carry out the 12-point program to combat drug abuse described by the Deputy Secretary of Defense in his Congressional testimony of 27 July 1978. The initiatives are treated under the various functional areas into which the Department of Defense Office of Drug and Alcohol Abuse Prevention Program is divided.

1. Assessment and research

a. Initiative.—Design and administer an anonymous personnel survey to measure the prevalence and consequences of drug and alcohol abuse.

The anonymous personnel survey of the active duty military force was completed and the report published in November 1980. Copies of that report were provided to the Select Committee; however, our conclusions are summarized below:

> Comparison of the use of drugs in the last 30 days in the Armed Forces (grades E1-E5) between 1974 and 1980 reveals that in all categories of drugs, except cannabis, drug use is down by 3 percent to 9 percent. Cannabis use overall in DoD remains the same between 1974 and 1980 but use in the Army and Air Force is down by 6 percent, the Marines are up by 4 percent, and the Navy is up by 12 percent.
>
> Alcohol is the most serious abuse problem in the Armed Forces.
>
> There are more than 130,000 substance-dependent members of the Armed Forces.
>
> There are large numbers of service personnel high or drunk on duty.
>
> The prevalence of drug and alcohol abuse in the military is about the same as it is in the civilian population from which the military are recruited.
>
> The resources committed and efforts made in the past six years have produced results. Of the 100 drug abuse statistics for which comparisons are available between 1974 and 1980 by drug, service, and geographical area, 88 are down, 8 are up and 4 are the same.
>
> The Air Force has significantly lower use rates and consequences than the other Armed Forces. The Naval service has the highest use rate and consequences.

b. Initiative.—Request epidemiologic assistance from the Center for Disease Control Epidemiologic Intelligence Service.

An epidemiological data aystem was established in the Department of Defense. It consists of a point prevalence assessment, a Department of Defense biennial personnel survey (paragraph 1a above) and continuing trend assessments, the Department of Defense drug and alcohol abuse reporting system (paragraph 1c below).

c. Initiative.—Redesign the drug and alcohol reporting system.

The reporting system is continually in a state of redesign, refinement and enlargement. The DoD now receives reports on aircraft accidents and mishaps where alcohol or drugs may be a factor. A new requirement to report urinalysis laboratory workload and heroin, cocaine and phencycladine positives by installation has been levied—by reporting positives by installation instead of confirmations as has been the case in the past, it is hoped to gain early warning of any new influx of these dangerous drugs into any given local area. The identification, confirmed urinalysis, and treatment and rehabilitation reports have all been redesigned and expanded upon. Law enforcement and disposition of drug abuse offenders reports are being added, and safety data to include the effects and costs of drug and alcohol abuse involvement on ground accidents and incidents is being examined for use in the reporting system.

The Drug Abuse Warning Network was examined for possible use by the Department of Defense. During the period October 1979–September 1980 a pilot project was conducted to determine the feasibility of adopting the DAWN. Thirty medical facilities representing of adopting the DAWN. Thirty medical facilities representing all services were involved. Technical and contract assistance was provided by IMS America, Ltd., of Ambler, PA., the Drug Enforcement Agency and the National Institute for Drug Abuse. The contract cost was $48,000.

The project results, which were reviewed by all services and in subsequent meetings between ODAAP and IMS America, do not warrant a DoD-wide implementation of the DAWN system for the following reasons:

> DAWN provides a limited assessment of substance abuse as a result of hospital emergency room visits. The high risk group of 18–24-year-olds primarily engages in episodic and experimental substance abuse and normally does not require or seek emergency medical treatment. It is, therefore, doubtful that the DAWN system would assist in better defining and addressing prevalence.
>
> DAWN is highly sensitive to short-term changes in substance abuse patterns which are more useful to local commanders and medical staffs.
>
> DoD-wide implementation of DAWN would ignore critical differences between services' missions and force structures which require distinct but generally compatible assessment and reporting systems. DAWN would duplicate and frustrate command program management.

The contractor proposal for an 18-month implementation effort costing $400,000 to $800,000 is too expensive, given the limited expected payoffs and the aforementioned problems.

The services have been given copies of the project final report with a recommendation to reexamine the results and the DAWN system design, which may suggest some useful modifications to existing local command assessment and reporting systems.

d. Initiative.—Determine the extent of drug and alcohol abuse among dependents.

Initially, it was proposed that a personnel survey would be administered to military dependents to determine the prevalence of drug and alcohol abuse in that population. However, it was found that a survey of the type required would be prohibitively expensive so the idea was dropped. Instead, it was felt that the National Institute on Drug Abuse, National Survey on Drug Abuse: Main Findings 1979 could be extrapolated to give reasonably acceptable estimates for the level of drug use in the different dependents age cohorts. Further, a special purpose survey of high school students is being developed now. This subpopulation is of special interest and the opportunity presented itself to have the survey done in conjunction with a NIDA survey of civilian sector students. This survey is elaborated upon later in this discussion.

e. Initiative.—Examine the relationship between drug and alcohol abuse and military performance.

Since 1979 the Office of the Secretary of Defense has supported a research program to investigate the consequences of drug and alcohol abuse on individual military performance, and combat effectiveness. This research, conducted by the Walter Reed Army Institute for Research for the Department of Defense is complex. It is also subject to competing military medical research priorities.

A comprehensive review of scientific literature on drug and alcohol abuse effects on individual performance was completed in December 1979. WRAIR concluded that further research in this area would be of questionable utility and cost prohibitive in terms of trying to isolate the effects of different substances on the performance of discrete tasks in various military occupational specialties without the use of human subjects. Results of civilian research, which can be reasonably extrapolated to the performance of military tasks, will be used as it becomes available.

Research on combat effectiveness has proceeded on two tracks. A computer simulation analysis of hypothetical combat performance degradation was completed in April 1980. This abstract analysis, which assumed varying levels of abuse for personnel less than 25 years old, was inconclusive, except for the fire direction elements of artillery units. The force structure of these units appears to be sufficiently flexible to permit reconstituting their combat capabilities after sustaining drug or alcohol abuse and combat casualties as high as thirty percent. A major limitation of this study is that it does not include an analysis of the human dynamics of drug abuse and troops in combat.

The second thrust of this research is a 41-week project to examine the effects of drug and alcohol abuse on the cohesion of tank crews. This project was started in March 1981 in USAREUR and preliminary results are expected by September 1981.

A related project, which is separately sponsored by the U.S. Army Institute for the Behavioral and Social Sciences, is designed to evaluate the relationships between unit command climate and combat readiness measures. The project involves four waves of data collected in fifty-five batallions between May 1978 and November 1979. Interim results indicate that substance abuse is one of twenty-one measures consistently used by senior commanders to assess unit effectiveness. The extent to which drug abuse scientifically correlates with quantitative and qualitative measures of climate and readiness is still being analyzed and results are expected later this year.

2. Deterrence and detection

a. Initiative.—Test portable urinalysis equipment.

The original test of portable urinalysis technology was completed in 1979. The technology was found to be inadequate. Since that time, portable kit technology has improved and consequently, new testing is under way. These portable test kit candidates are now undergoing evaluation at one of the DoD established laboratories where their results are compared to the results of the fixed equipment. This technical testing should be completed shortly. If any of the equipment operates satisfactorily, the DoD may enter on a full-scale field test.

b. Initiative.—Determine adequacy of law enforcement personnel.

The Department of Defense Law Enforcement Task Group first reviewed the law enforcement staffing in Europe in 1979 and has continued to monitor it since that time. Manpower authorizations were increased in fiscal year 1979 and are projected to be increased again in fiscal year 1982.

c. Initiative.—Determine the adequacy of disposition procedures of civilians apprehended for drug offenses on military installations.

The Department of Defense Law Enforcement Task Group twice reviewed the problem associated with civilians arrested on military installations for drug offenses who were not subsequently prosecuted by civil authorities. The Task Group twice concluded that the problem was not of sufficient size to merit extraordinary action at the Military Department level. Local military law enforcement agencies are sensitive to the issue and are managing the problem satisfactorily.

d. Initiative.—Establish a Berlin Task Force to focus on the problem in that city.

The Berlin Task Force was formed and continues to function effectively to coordinate counter-drug matters in Berlin. Chairmanship of the Task Force has passed from the U.S. Commander, Berlin to the Governing Mayor of Berlin.

3. Education and rehabilitation

a. Initiative.—Reemphasize the significance attached to curtailment of drug and alcohol abuse to command and medical personnel.

All visits proposed by Mr. Duncan under his fifth initiative to include his visit to Europe on Exercise Reforger were accomplished. In addition, the Special Assistant for Drug and Alcohol Abuse and more recently the Deputy Assistant Secretary of Defense (Drug and Alcohol Abuse Prevention) have pursued an aggressive policy of staff visits. The DASD (DAAP) has made such visits to Germany, England, Japan, Okinawa, Korea, Hong Kong, the Philippines, as well as installations in the CONUS, Hawaii. He has made it a policy to get out of the office and visit some installations once or twice a month. In addition, the ODAAP staff officers are continually traveling and looking at service programs from the point of view of their own expertise. All in all, the ODAAP is emphasizing and reemphasizing drug and alcohol abuse control to commands and staff alike through a vigorous, pervasive, in-depth system of staff visits.

In addition, the services developed and implemented standard lesson guides for supervisors, non-supervisors and dependents in 1979.

f. Initiative.—Develop and test program evaluation criteria.

Alcohol and drug abuse television spot announcements were developed and evaluated by NIDA in 1979. The Department of Defense continues to use NIDA and NIAAA-developed radio and television spot announcements on the Armed Forces Radio and Television Services Network. In addition, the DoD purchases pamphlets from both NIDA and NIAAA Clearinghouses that are appropriate for DoD audiences.

Ongoing cooperation between the DoD and other Federal Agencies is evidenced by the several interagency committees and working groups on alcohol and drug abuse on which DoD maintains representation.

A DoD Instruction on rehabilitation and referral is presently in the formal coordination process and is expected to be issued by August 1981. The Instruction provides standards for residential and non-residential rehabilitation, as well as for referral in the areas of staffing, program components and quality assurance. These are based on the guidelines developed by the Joint Commission on the Accreditation of Hospitals.

4. Command

a. Initiative.—Increase the size and quality of the DoD drug and alcohol abuse prevention staff.

Action to upgrade the Department of Defense Alcohol and Drug Abuse Prevention staff was completed in 1978. Additionally, the position of Special Assistant for Drug Abuse was upgraded to that of Deputy Assistant Secretary of Defense (Drug and Alcohol Abuse Prevention) in 1980 and filled by an active-duty Brigadier General with extensive command and personnel experience.

NEW DRUG AND ALCOHOL ABUSE CONTROL INITIATIVES

Described below are a number of new actions initiated by the Department of Defense in the area of drug and alcohol abuse control. They also are listed by the functional groupings of the Office of Drug and Alcohol Abuse Prevention.

1. Assessment and research

a. After the completion of the analysis of the 1980 worldwide military survey of drug and alcohol use, several additional topics were judged of such importance that further study of them was warranted. Due to funding limitations, these additional analyses were conducted with computer support from the Army. The topics of study concentrated on the reasons for and for not using drugs or alcohol, consequences of substance use, and family member's need for help with substance problems. The analyses have been completed and the findings are presently being written.

A few of the preliminary findings are:

- The primary reason given for use of drugs or alcohol was to relax or unwind.
- The primary reason given for not using drugs or alcohol was fear for health.
- Over half of those who do not drink stated that the high cost of alcohol was a prohibitive factor.
- At least 1 percent of all military personnel have an alcohol or drug problem at least annually which is bad enough as to require medical treatment.
- Twenty-three and seven-tenths percent of military personnel are heavy users of drugs or alcohol.
- Eight and six-tenths percent of military personnel are dependent on either drugs or alcohol.
- Of the military personnel who exhibit signs of dependence on drugs or alcohol, 28.4 percent reported impairment on 31 or more days annually as compared with 2 percent of the occasional users.
- The heavy cannabis users reported a significantly higher percentage of impairment than did the occasional cannibis users.

b. New initiatives in the form of personnel surveys of other segments of the Department of Defense family are being developed. A survey of dependent high school seniors overseas is being planned in conjunction with the National Institute on Drug Abuse annual survey of civilian high school seniors. The DoD wishes to find out how dependents compare with their peers in civilian life in the area of drug and alcohol abuse; there is speculation that the nomadic, often disruptive life style experienced by dependent children may lead to serious drug problems.

c. A survey is also being undertaken of DoD civilian employees. The DoD bears a responsibility for prevention, treatment and rehabilitation of drug and alcohol abusers in the civilian work force. However, it is necessary to establish a measure of prevalence in the target population in order to best determine how to treat the problem.

d. Finally, the DoD is collaborating with the Office of Personnel Management and the National Institute on Alcohol Abuse and Alcoholism in a study designed to examine the components of a civilian employee drug and alcohol abuse control program to determine what does and does not affect effectiveness.

e. The Office of Drug and Alcohol Abuse Prevention has also explored the drug and alcohol abuse and combat effectiveness research issue with the National Academy of Sciences' Assembly of Behavioral and Social Sciences. The Academy is refining a preliminary proposal for determining alternative methods for assessing the effect of drug and alcohol abuse on combat effectiveness, discipline, and performance. The study, which would cost an estimated $350K in the first year, would seek to identify appropriate analytical criteria for assessing drug and alcohol abuse effects and make recommendations regarding methods for the empirical determination of these effects. DoD approval, however, is still subject to review of the final proposal and availability of funds.

f. A joint Department of Defense/National Institute on Alcohol Abuse and Alcoholism research project to develop and validate a clinical technique for detecting alcoholism using the results of routine blood chemistry tests is in progress at the National Naval Medical Center. Preliminary results are expected by September. The Department of the Navy is also expanding the research to include the Naval Drug Rehabilitation Center in San Diego.

2. Deterrence and detection

The emphasis on the deterrence and detection of drug and alcohol abuse has been increased. Drug intelligence collection has been improved through meetings, briefings, report-sharing and dissemination of drug advisaries. Urine testing for drugs of abuse has continued to be emphasized and rendered more cost effective. A consolidation of laboratories is planned; cocaine testing has been increased; and regional analyses of urine testing trends have been prepared. An unequivocal stand on drug paraphernalia has been taken, and incorporated in a DoD Directive. Where appropriate, local Disciplinary Control Boards and off-limits sanctions are being used against establishments dispensing drug paraphernalia. Finally, a cost benefit evaluation of drug and alcohol abuse prevention programs is being pursued.

3. Education and rehabilitation

a. In August 1980, the Department of Defense issued a new directive on alcohol and drug abuse policy. The Directive combined alcohol and drug abuse programs for both military personnel and DoD civilian employees, and included policy on drug abuse paraphernalia and trafficking.

b. On 5 December 1980, DoD Instruction 1010.5 was issued which established policy on alcohol and drug abuse education and training.

c. The DoD has continued to provide education and training opportunities to its personnel through its annual worldwide conferences on alcohol and drug abuse. The third annual conference will be held in August 1981 and will offer professional development tracks on rehabilitation, education and civilian programs.

d. In April 1981 proposals were submitted for evaluation to operate the Pentagon Employee Referral Service, an employee assistance program for DoD civilian employees working in the Pentagon complex. The PERS is scheduled to open on 1 July 1981.

HQ USEUCOM ACTIONS AND INITIATIVES

A. Introduction

Prior to 1976, HQ USEUCOM role in the anti-drug abuse effort was restricted to an annual requirement to collect drug abuse data and develop information papers in support of the USCINCEUR appearance before congressional armed services committees.

Responding to a perceived need, in 1976 HQ USEUCOM organized a semiannual Tri-Service Drug/Alcohol Abuse Symposium. This organization, still in being as a slightly modified body meeting annually, assembles key personnel associated with all areas of drug abuse (drug intelligence, detection, apprehension, prevention and rehabilitation), and from applicable organizations and activities (USEUCOM Component Commands, DOD, State Department, American Embassies, Drug Enforcement Admin.) to exchange information, techniques, experiences and to coordinate actions and programs requiring a unified effort.

Following White House Policy Staff interest, during March 1978 the USCINCEUR directed HQ USEUCOM to ". . . take the lead in developing corrective actions and programs to counter drug abuse within the U.S. European Command". Foremost among our problems at this time was a complete lack of a method to determine the magnitude and nature of the drug abuse problem within the command.

B. Specific initiatives

During April 1978, a drug abuse seminar was conducted at HQ USEUCOM for the purpose of establishing standardized drug abuse terminology, standardized methods of identifying and reporting drug abuses and a tri-service drug abuse report format. The European Command Directive 30–17, which accomplishes the above, was developed and, with some modifications, is still in use.

To insure that our efforts to date and our initiatives for the future were properly oriented, during August 1978 a General/Flag Officers drug abuse review meeting was conducted. The participants, drawn from line organizations, verified our efforts to date and affirmed that we should (1) develop a credible system to measure the problem and establish a base against which future efforts can be compared, (2) direct command attention to the problem, (3) increase law enforcement and intelligence efforts and direct a major effort to attacking the sources of production and disrupting the international movement of drugs, (4) increase anti-drug abuse program manpower and levels of proficiency, and (5) increase U.S. and host nation coordination and interoperability in the anti-drug effort.

Following a history of concerted effort by the American Embassy Bonn to increase German-American cooperation in the drug abuse field, in June 1978, U.S. Ambassador Stoessel and German State Secretary van Well signed a U.S./FRG Narcotics Control Agreement. The agreement made formal some aspects of past cooperation, while outlining broader, mutual, bilateral and multi-lateral efforts to suppress the production, distribution, and use of illegal drugs. The agreement established a Central Working Group chaired at the ministry level and four subcommittees: Prevention/Medicine; Legal; Police and Customs Enforcement Measures; and Military. This organization provided the European Command the vehicle to permit direct interface at the highest German military, medical, government and law enforcement levels. Working with and through the American Embassy, Bonn, HQ USEUCOM procured permanent U.S. military representation on the Central Working Group (1 position) and the subcommittees (12 positions). This unique organization has in the past and continues to prove invaluable in our overall anti-drug abuse efforts.

Acting to support our new programs with adequate resources, on 7 November 1978 HQ USEUCOM consolidated European Command added personnel needs and requested an additional 439 personnel be authorized to implement our new and improved anti-drug abuse programs. To date, all requested positions have been approved and a majority have been filled.

At this period, the House Select Committee on Narcotics visited Europe and conducted hearings on drug abuse at HQ USEUCOM on 20-22 November 1978. We found the committees' findings to be direct, fair and constructive. Their findings, in many instances, supported and gave credence to previous HQ USEUCOM positions, i.e., the high availability of very pure but inexpensive drugs in Europe was a major contribution to the problem; and, international suppression efforts are a necessary part of any attempt to attenuate the problem. Indeed, these findings were significant contributors to our efforts to justify increased resources.

Following the House Select Committee visit, HQ USEUCOM and the Component Commands moved to formulate programs in response to the committees' findings. The specific programs developed by the Component Commands are attached to this report.

Having completed necessary programs to insure proper coordination between the military agencies involved, standardized identification and reporting procedures and procuring increased resources, HQ USEUCOM turned its efforts to coordinate and enhance the interoperability between U.S. military and other U.S. agencies and host NATO country law inforcement activities in reducing the production and international trafficking of illegal drugs.

Our initial effort was the establishment of a single point of contact between all U.S. military law enforcement agencies in Europe and other U.S. agencies (State Department, Drug Enforcement Administration, Defense Attaches, United States Customs Service and information/intelligence gathering organizations) involved in anti-drug trafficking activities. Also, this point of contact would be the interface between the U.S. military and foreign military drug related intelligence gathering and law enforcement agencies. This point of contact was an office of four personnel, specialists in their fields and bilingual, headed by a GS-15 civilian titled the Special Assistant for Drug Enforcement Matters (SADEM).

The SADEM is the USEUCOM representative to the Central Working Group (CWG) and the Police and Customs Subcommittee, both action bodies of the US/FRG Narcotic Control Agreement previously mentioned. In addition, he coordinates the U.S. military efforts of the other subcommittees (Legal—Military—Prevention and Medical) in close cooperation with U.S. State Department, Customs Service and Drug Enforcement Administration personnel.

During this initial period, a most difficult task was to convince German officials that they faced a serious drug abuse problem that, because of the amounts of high quality, low price drugs available, could become deadly serious. In close coordination with American Embassy, Bonn, and working through established channels of communications we were able to convince the Germans of the seriousness of this matter. This effort was considerably enhanced by our repeated use of a statement made by Representative English during a November 1978 interview that ". . . unless the Federal Republic of Germany takes action to clean up and control drug abuse, Americans will question the feasibility of sending military personnel to Germany."

Lessons learned from the drug enforcement initiatives in Germany are being applied in other host nation countries. HQ USEUCOM has developed briefings that outline the U.S. military experiences and programs and have presented them to various international bodies, i.e., U.S. Delegate to NATO Military Committee (USDELMC), the NATO Military Committee, the Portuguese Armed Forces General Staff, the Civilian Center for Investigation and Control of Drugs, Dutch Narcotics Enforcement Agencies, and the Central Working Group for US/German Joint Narcotics Control. We have volunteered to provide our expertise to other European countries and agencies in order to solicit their support in international interdiction and suppression of drugs.

These offers are frequently accepted and we are now, in response to specific requests, developing programs to apprise the Armed Forces General Staffs of Portugal and Italy of the U.S. military experience with drug abuse and offer suggestions on how they can address the budding problem in their armed forces. Such programs are proving valuable in establishing the international relations so important to a comprehensive effort attacking the spectrum of the drug problem from production and distrubution to abuse and rehabilitation.

C. Summary

The European Command has a drug abuse problem. This problem, by its very presence and the resources dedicated to attenuate its magnitude, detracts from readiness. Over the past three years we have mounted a concerted and coordinated program to attenuate the problem by applying pressure to all phases of the drug abuse environment—from the production to the use of illicit drugs. We know that success will not come through some spectacular break-through or crowning achievement but through the persistent application of well conceived, staffed and financed anti-drug abuse programs.

U.S. AIR FORCE EUROPE (USAFE) ACTIONS AND INITIATIVES

A. Introduction

During the two years since the Representative English hearings USAFE has initiated a comprehensive series of anti-drug programs. Foremost among these is "Counterpush", USAFE's intensified program to counter the growing drug threat in Europe. Counterpush I was designed to interdict drug supplies through intensive education and increased awareness of positive alternatives to abuse. In April 1980 Counterpush II was launched to sustain suppression efforts and focus on quality of life issues. Positive results have been realized; however, much work remains to be done and the effort continues.

B. Specific initiatives

(1) Significantly important has been the considerable addition of manpower dedicated to the entire spectrum of anti-drug abuse programs. These increases were dedicated to enhance investigative, detection, interdiction, apprehension and rehabilitation programs. Manpower authorizations were increased for Security Police Investigators, Office of Special Investigation (OSI) Investigators and Law Enforcement personnel, Drug/Alcohol Abuse Control manpower for Social Actions, Administration, Rehabilitation and Judge Advocate personnel. These additional manpower positions were authorized and filled in fiscal year 1979–80.

(2) Assessment capability was enhanced through the development of a Drug Threat Assessment Program which provided all USAFE bases a standardized system for determining the relative drug threat and provided the data to develop an overall command assessment. The Air training Command Drug/Alcohol use survey was administered as part of this ongoing assessment.

(3) Educational training concerning drug abuse practices and paraphernalia has been increased and awareness improved through development of seminars, multimedia publicity campaigns and restructuring of supervisory training courses at all command levels. Up-to-date drug education is now included in all USAFE and base-level professional military education courses. Annual Drug/Alcohol Refresher seminars are required for all Commanders, First Sergeants and Supervisors. Paraphernalia kits and concealment technique guides have been developed to assist authorities in recognition and concealment practices utilized by drug abusers and traffickers. Education seminars are now provided for all first-term arrivals. The program provides drug education to all new first-term personnel to include the limited privilege communication concept, whereby an individual may turn himself in for treatment and, Operation Pit-Fall which educates the individual on host country laws. Extensive predeployment briefings concerning drug threat information, host nation laws and the USAFE COUNTERPUSH efforts were prepared by USAFE and are presented to CONUS units deploying to Europe.

(4) Coordination with host nation pharmacies to preclude their selling controlled substances to U.S. military personnel.

(5) Detection capabilities were reviewed and improved as follows:

Established urine testing at 120 percent level of the target age group (17–25 years old) command wide.

Trained hospital emergency room personnel to detect signs of drug abuse in patients.

Extended surveillance testing from 30 to 180 days for all personnel producing unexplained positive urinalysis tests.

Increased the use of and number of drug detector dogs. This effort has generated a considerable amount of interest and action among host nation enforcement agencies who are now considerably expanding their own drug detector dog capability.

Established a program for utilization of amnesty boxes whereas a user or possessor of controlled substances or paraphernalia can dispose of this material prior to being identified. This practice does not identify individuals; however, it provides invaluable information concerning possible areas of drug abuse activity, different types of drug paraphernalia used and types of substances abused.

(6) Emphasized a policy to allow first time cannabis abusers to attend a seminar and to employ educational training rather than committing the first time user to a rehabilitation program. This alternative is at the Commander's discretion and usually results in the person returning to work sooner. Personnel are screened and those cannabis users with the potential for continued abuse are entered into rehabilitation programs.

(7) Established action to enhance community involvement to better organize dependents and civilian community members in their efforts to counter drug abuse. A Youth Involvement Program was developed to create interest in wholesome activities available as alternatives to drug usage.

(8) Positive Peer Pressure Groups under the "COUNTERFORCE" program have been organized to contact newly arrived personnel, and show positive aspects of overseas life, educational and recreational opportunities and ways to live and work in Europe without resorting to drug-alcohol usage. This program results from the independent initiative of young Air Force personnel working to provide a better environment for their newly arrived comrades.

C. Summary

Over the past two years, management trends indicate a significant reduction in hard drug use and a slight decline in cannabis use in USAFE. Drug suppression efforts continue at a high level and commanders quickly identify abusers. Law enforcement efforts and off-base interdiction activities, through joint service operations and host nation enforcement agencies, continue to combat the sale and trafficking of drugs. The efforts to date have provided positive indications that we can counter drug abuse and that the drug threat for uniform, civilian and family members associated with USAFE, can be reduced.

U.S. NAVY EUROPE (USNAVEUR) ACTIONS AND INITIATIVES

A. Introduction

(1) Drug abuse among U.S. Navy and Marine Forces assigned to CINCUSNAVEUR presents a different pattern and is a different nature than USAREUR and USAFE. The smaller numbers of personnel assigned, the transient nature of forces deployed to USNAVEUR, confined working and living quarters and the extended work hours while at sea, all provide a great degree of control and limit to drug usage. Basically, USNAVEUR has a soft drug abuse (cannabis) problem, with little usage of hard drugs. Shore based USNAVEUR personnel are older than the average force age and the majority are over or approaching the upper limit of the high usage target age group, (25 years and younger).

(2) While USNAVEUR was not involved in the English drug abuse investigations and hearings; they participate in, and are responsive to the entire range of European Command drug abuse detection, identification and rehabilitation efforts.

B. Specific initiatives

(1) In December 1978, CINCUSNAVEUR tasked Commander Sixth Fleet to conduct a one time assessment of the scope and nature of the drug problem within the Sixth Fleet and to determine the associated impact on operational readiness. The results of this assessment have proven useful as a baseline reference for comparison.

(2) In the first calendar quarter of 1979, HQ USNAVEUR established a requirement to conduct a monthly review and in-house report concerning drug abuse. The substance abuse staff conducts the monthly review and prepares a report for the CINCUSNAVEUR and other key staff officers.

(3) Substance abuse personnel established a USNAVEUR substance abuse quarterly newsletter as an informal publication designed to promulgate timely information regarding professional developments, changes in policy, substance abuse training, advance information concerning forthcoming directives and review of existing policies and directives. Wide distribution throughout USNAVEUR and to selected addressees insures the dissemination of timely drug abuse information to all echelons.

(4) Urinalysis testing programs were supplemented by the implementation of a CINCUSNAVEUR-directed urinalysis testing program of individual commands. Selection of units to be tested is based upon available intelligence about the drug abuse patterns of individual units and/or the ports being visited. Sufficient units are selected to meet established testing quotas.

(5) To meet the needs of the large Navy population in the Naples area, USNAVEUR established a Counseling and Assistance Center (CAC) and a Navy Safety Action Program (NASAP) site in Naples, Italy. The CAC is an outpatient drug screening and counseling activity which complements an already existing Alcohol Rehabilitation Service (ARS) at the Navy Regional Medical Center, Naples. The NASAP, Naples, administers an after hours education program designed primarily for personnel involved in alcohol related incidents.

(6) In the first quarter 1980, CINCUSNAVEUR directed the establishment of a Drug and Alcohol Abuse Control Board. This board was established to conduct a periodic, high level review of the USNAVEUR substance abuse problems, and to ensure that policy and program resources are commensurate with the magnitude of

the problem. The board is chaired by the DCINCUSNAVEUR and consists of eleven key staff officers. At minimum, the board convenes quarterly.

(7) In March 1980, USNAVEUR implemented a comprehensive quarterly drug and alcohol abuse report. This report is submitted quarterly by all USNAVEUR activities, directly to CINCUSNAVEUR. The report includes various indices which improve the ability to monitor the scope and nature of USNAVEUR substance abuse trends, thereby permitting corrective programs to be developed.

(8) A combined CINCLANTFLT and CINCUSNAVEUR comprehensive quarterly drug and alcohol abuse report is used to report substance abuse data. This coordinated effort established standardized urinalysis policy, procedures and reporting for CINCLANTFLT deployed units and USNAVEUR activities. Explicit guidance to overseas homeported and deployed units is provided to obviate dual reporting and conflicting testing policy and procedures.

(9) Successful drug interdiction and investigative operations have been conducted by the Naval Investigative Service (NIS) and local police in Rota, Spain; Naples, Italy; and Alexandria, Egypt.

C. Summary

USNAVEUR continues to report a relatively small magnitude of drug abuse among their forces. With a small shore based population and a large deployed operational force, USNAVEUR enjoys the advantage of being able to closely observe and supervise the drug abuse environment. During the two years since the Representative English Committee Hearings, USNAVEUR has considerably expanded and strengthened its drug abuse detection interdiction and reporting techniques and procedures.

USAREUR INITIATIVES

1. Initiative

Improve education to include development of a better drug abuse orientation for all incoming personnel, to be followed by programs tailored specifically for senior NCO and officers, junior leaders, and troops.

Status.—Drug and alcohol awareness orientation is provided all newly assigned E-1 to E-4 within hours of arriving in USAREUR.

A three module drug briefing suitable for senior NCO and officers that includes a discussion of the medical hazards of drug abuse, drug program, and drug abuse trends and indicators was developed and distributed to MACOM, divisions and separate brigades.

USAREUR Pam 600-3, Commanders, Supervisors and Staff Officers Guide to the USAREUR Alcohol and Drug Abuse Prevention and Control Program, has been developed and published.

The USAREUR Drug and Alcohol Assistance and Education Team (UDAAET) developed training packets for use at community, battalion and company level.

The UDAAET is visiting communities to assess drug education programs and to evaluate the effectiveness of drug education training provided by 7th Army Training Command.

2. Initiative

Make programs to suppress drug abuse an item of increased USAREUR Inspector General (IG) interest.

Status.—The USAREUR IG has made the Alcohol and Drug Prevention and Control Program a matter of special interest and assesses the following:

Unit compliance with regulatory procedures.

Qualifications and training of unit drug alcohol education specialists.

Quantity and quality of services provided by Community Drug and Alcohol Assistance Centers.

Unit personnel are questioned concerning the presence of chain-of-command in the barracks during non-duty hours.

Unit physical readiness training and sports programs are evaluated.

Community support for all aspects of the ADAPCP.

3. Initiative

Increase command presence in the barracks during off-duty hours and increase the NCO Chain-of-Command involvement in combating drug abuse.

Status.—In Mar. 79, CINCUSAREUR directed that all subordinate commanders increase command presence in the barracks during non-duty hours. Most commands are requiring NCO or officers to visit barracks during non-duty hours; some commands are requiring single junior NCO to reside in billets; others have developed programs consisting of seminars or classes focusing on the NCO chain-of-command involvement in combating drug abuse.

4. Initiative

Establish a USAREUR Drug Assistance/Assessment Team.

Status.—DA authorized USAREUR three officer and 12 enlisted spaces to form a Drug Assistance/Assessment Team. The team was organized and staffed in July 1979 and promptly began staff visits to USAREUR communities. The purpose of the team is to assess the drug situation at community and unit level and provide commanders with assistance to overcome shortcomings and improve the ADAPCP. As of Aug 80, the team has provided assistance and conducted on-site assessment of the drug situation and program in 33 USAREUR communities.

5. Initiative

Establish a media consultant group.

Status.—In late 1978, a media consultant group was established to review the existing media effort and recommend actions to improve the quantity and quality of publicity afforded USAREUR's Alcohol and Drug Abuse Reduction Program. Since 1 January 1979, broadcast elements have used the consultant group's recommendation to develop 15 new radio spots, two full-production television features on substance abuse and three special reports relating to drug abuse. These productions have received more than 700 exposures. Additionally, the printed media has used the consultant group recommendations to develop an estimated 150 articles and features on drug abuse.

6. Initiative

Identify and assist the host nation in expelling from the FRG US civilians who are involved in drug trafficking.

Status.—Members of the legal subcommittee, US-FRG Central Working Group for Narcotics Control, agreed on mutual cooperation to assist in the denial of work permits or residency permits under circumstances where the individual is a known drug trafficker and may be a threat to the welfare of the military or civilian community.

7. Initiative

Maintain close working relationship with US, host nation, and other European law enforcement agencies.

Status.—Previously, representatives of the Provost Marshal office met regularly with the Southeast, the Dutch-German, and the French-German Drug Working Groups. However, with the creation of the Special Assistant Drug Enforcement Matters (SADEM) at US European Command, some responsibilities have been transferred to that office. The Drug Suppression Operations Center regularly interacts with the SADEM. Areas of military concern for consideration at the various working groups are focused through the SADEM, and broader international crime trends and directions are briefed into military channels by the SADEM.

8. Initiative

Increase the quality of service provided by the Community Drug and Alcohol Assistance Centers (CDAAC).

Status.—The quality of counseling provided in CDAAC was substandard in 1978. USAREUR request 50 additional clinical directors at the GS-11/12 level and 40 additional civilian counselors at the GS-7/9 level. USAREUR received 30 additional clinical directors and 40 additional senior military behavioral science specialists in fiscal years 1979 and 1980. The impact of these additional resources has been considerable. The credibility of CDAAC services both with unit commanders and local medical personnel has improved greatly. Rehabilitation success rates have improved for various categories of abusers from 9 to 20 percent. The overall success rate has improved by approximately 11 percent. This represents manpower savings for USAREUR of several hundred personnel and millions of dollars annually.

9. Initiative

Provide planning support for USAREUR community drug suppression operations.

Status.—Each community has a drug suppression plan which has been reviewed and approved by USAREUR. To insure that the plans are given proper visibility and emphasis at community level, the DSOC requested compliance with durg suppression regulations be evaluated by the USAREUR Inspector General. During fiscal year 1981, IG teams will assess community drug suppression activities as part of the IG inspection.

10. Initiative

Design and administer a Personnel Opinion Survey.

Status.—Since 1974, USAREUR has conducted a Personnel Opinion Survey at least annually to determine the size of drug abuse problem. Over 50,000 soldiers have been surveyed on an anonymous basis. The survey has proved to be a useful and reliable assessment tool. In addition to continuing the survey on an annual basis, special surveys are conducted when needed.

11. Initiatives

Establish a Berlin Drug Task Force designed to focus on the singular problem of that free port.

Status.—On 30 June 1978, the US Commander Berlin convened a meeting of all agencies involved in combating the flow of drugs into and through the Western sectors of Berlin. The objective was to determine the extent of the problem, the impact on the American and German communities, American involvement in drug trafficking, and actions that could be taken by the US Military Command structure, US State Department, Drug Enforcement Agency, US Military Law Enforcement Agencies and West German Police and Customs officials to control the drug flow. The following task force goals were established:

Determine measures to interdict the drug flow.

Determine measures to isolate the American community from the drug flow.

Determine programs or actions to assist German law enforcement agencies in improving their capability to combat drugs.

Since January 1979, drug abuse indicators for US Army, Berlin have shown a steady decline, thus, reflecting an apparent program success.

12. Initiative

Increase use of Selected Unit Urine Testing (SUUTCO).

Status.—SUUTCO was implemented in May 1978. For the six month period prior to CODEL English visit, an average of three tests per week were conducted. Since then, 681 tests have been conducted for a weekly rate of seven tests. During the first year of testing, about 20 percent of all tests were directed from HQ USAREUR; however, in recent months increased commander confidence in the program has resulted in most requests coming from company or battalion commanders. The percentage of positives detected through SUUTCO stabilized at about 2.4 percent in 1979, but the percentage of positives for opiates declined by 50 percent in recent months. SUUTCO has proven valuable to commanders since it provides an indication of drug abuse levels at a point in time, thereby helping to determine the impact on readiness. Also, SUUTCO information is used to plan special drug suppression operations.

13. Initiatives

Increase the number and quality of personnel assigned drug prevention and control related duties.

Status.—In addition to the increased law enforcement resources mentioned above, a substantial increase in manpower and fiscal resources to enhance identification and rehabilitation programs was requested from DA.

The following resources were added to the ADAPCP in fiscal years 1979 and 1980:

Six officers and 17 enlisted personnel to support USAREUR's Drug Education and Assessment/Assistance Teams: 30 (GS 11/12) Clinical Directors; 40 senior grade military counselors; 1.7 million dollars annually.

Other additional resources beginning in fiscal year 1981: 40 (GS 9) civilian counselors; four (GS 13) physicians; eight (GS 11/12) psychologists; eight (GS 7) social service assistants; 1.6 million dollars annually.

14. Initiative

Encourage greater efforts to keep soldiers busy in wholesome activities during off-duty time.

Status.—USAREUR is field testing an integrated on-duty and off-duty sports program to provide a varied program of activities at company and battalion level. Armed Forces Recreation Center adventure training opportunities have been expanded. Low-cost, structured tours/travel for junior enlisted personnel have increased.

UPDATE OF MILITARY SERVICE ACTIVITY IN EUROPE—HQ USEUCOM UPDATE ACTIONS AND INITIATIVES

A. Actions to further NATO initiatives—

1. Completed two follow-up briefings and discussions with the Portuguese armed forces general staff and Iberian Atlantic on U.S. military drug threat, threat analysis, programs for identification, treatment and education of drug users within the military.

2. Completed two briefings and discussions by a tri-Service USEUCOM team for Chief of Staff, Italian Ministry of Defense and 80 staff members to include customs,

police, medical officers and chaplains on identification, treatment and education for drug users in the military forces, service academies, and medical doctors. An international conference is scheduled in Rome, 3-5 June 1981.

3. Two discussions were held between HQ USEOCOM Special Assistant for Drug Enforcement Matters (SADEM) and Norwegian military enforcement officials. Topics covered were U.S. Forces participating in NATO exercises in Norway and transporting illegal drugs and alcohol. Action to request special briefings and information to all deploying operational units from CONUS were undertaken by HQ USEUCOM. A Norwegian official plans to visit U.S. law enforcement agencies in Germany this summer.

4. Two meetings each with Dutch and Belgian officials were held to discuss drug abuse identification programs and cooperative law enforcement operations. This HQ and HQ USAFE held two discussions with Canadian Forces-Germany on alcohol rehabilitation and U.S. military drug programs.

B. European Command Directive, ED 30-17, Drug Abuse Reporting, was revised to improve the component, command reporting and to provide more complete data. Effective 1 January 1981, component reporting includes alcohol abuse statistics (as well as drug abuse statistics) and drug related deaths. Component command substance abuse data will provide a more realistic substance abuse picture for the coming year.

C. Drug intelligence production continues to receive close attention for timely evaluation of the drug threat to DoD personnel in the USEUCOM area of responsibility. Data is collated from all source reportings, i.e., host nations, Interpol, UN Division of Narcotics Drugs, DEA, customs and defense attaches, American Embassy narcotics coordinators, U.S. military law enforcement agencies (USMLEA), and component commands. Collection and distribution activity is both through direct liaison with and between these agencies and participation in regional, national and international drug abuse conferences by the USEUCOM-SADEM.

D. Drug enforcement interoperability between USMLEA, DEA and host nation counterparts continue to be fine-tuned based upon evaluated drug intelligence and joint drug suppression operations in areas which host concentrations of U.S. Forces. These operations include joint usage of information sources, operational funds and material assets.

E. Initiatives to enhance all mutually supporting programs (education, prevention, detection, and treatment) are developed in coordination with the host countries and the above-listed U.S./international agencies. The U.S./German Narcotics Control Agreement has been a highly effective instrument in working such initiatives. A list of U.S. proposals which was presented under this Agreement to the Central Working Group on 24 April 1981 follows:

1. Drug trafficking and illegal revenue—measures seeking to attack financing assets of narcotics traffickers.
2. Drug threat assessment—assessment of the drug threat in areas surrounding storage/delivery systems of special weapons manned by U.S./NATO units.
3. Quality of life programs at community level—joint usage of education, prevention, detection and treatment programs within the host nation/military community to achieve alternatives for quality of life improvement.
4. Joint drug abuse assessment and countermeasure programs at the community level—joint usage of all source data, i.e., medical, social, and law enforcement, to analyze both the domestic/military drug abuse scene and design joint countermeasures.
5. Drug trafficking threat to military transportation system—measures to identify vulnerabilities that may be exploited by narcotic traffickers.

USAFE ACTIONS AND INITIATIVES

A. Continued the counterpush effort throughout the command to insure a nononsense, firm approach to the concept that USAFE will not tolerate drug abuse. Reaffirmed individual accountability for behavior, early recognition and identification.

B. In 1980, there were no drug-related fatalities in USAFE. Drug-related incidents decreased in 1980 compared to previous years. Confirmations of drug abuse from urinalysis testing decreased from six in 1000 in 1978 to 3 in 1000 in 1980. Hard drug identifications decreased from 271 in 1978 to 160 in 1980.

C. Off-base interdiction efforts increased through joint operations with host nation and USAREUR counterparts. Drug detector dog team strength has more than doubled since 1978. Active liaison with USAREUR Drug Suppression Operations Center insures maximum suppression resources.

D. USAFE officials continue to seek approval for first class mail inspection to discourage drug smuggling through the mail. U.S. Postal rulings limit inspections to second and third class mail.

E. Judge Advocate manning was increased to handle the additional workload generated by counterpush efforts.

F. Pre-briefing of USAFE inbound personnel informs all individuals of the drug threat and the programs to counter drug abuse as well as educating new personnel on the risks of drug usage and drug possession while in USAFE. Outbound personnel are also counseled prior to departing USAFE. Deploying operational units are pre-briefed on the drug threat prior to deploying to Europe.

G. Drug and alcohol abuse services are provided for family members. Family involvement in counseling and rehabilitation are stressed. Leisure awareness programs to educate personnel in developing skills and interests as alternatives to drug usage are stressed and continually reviewed.

H. Annual command First Sergeants/supervisor seminars are conducted. This provides drug abuse education to all supervisory personnel and enhances the supervisor's ability and willingness to identify drug users as well as their responsibilities in the rehabilitation process.

USNAVEUR ACTIONS AND INITIATIVES

A. Instituted increased urinalysis testing through an aggressive CINC-directed testing program which exceeded the previous DoD sixty percent level of the target age group.

B. Instituted a planned continuing semi-annual drug and alcohol abuse counselor refresher training seminar to upgrade and update all counselor resources within the command.

C. Expanded the Navy Alcohol Safety Action Program in the Naples area to include five additional outlying commands.

D. Naval Investigative Services continued to conduct task force operations in conjunction with port calls by major combatants throughout the Mediterranean. These operations are designed in conjunction with host nation officials to identify and arrest local drug dealers who target naval personnel for potential sales.

E. Naval Investigative Services is in the process of establishing a forensic drug laboratory at Naples for quick identification of suspect substances seized during drug use suppression efforts.

USAREUR ACTIONS AND INITIATIVES

A. USAREUR has continued efforts to reduce substance abuse and rehabilitate abusers. USAREUR Action Plan for Reduction of Drug Abuse (12 June 1980) remains a valid document.

B. Drug suppressions remains number one law enforcement priority. HQDA approved increase of 118 personnel to be used for joint drug suppression teams, dog handlers, and investigative teams. Second region CIDC received six additional drug coordinator special agent authorizations from HQ CIDC. Final HQDA approval was received for the 110 personnel authorizations requested in 1978 for medical staff, counselors clinical directors and program management staffing.

C. Drug sales and trafficking cases declined in 1980 due to increased interdiction efforts. Total heroin seizures increased significantly in 1980 versus 1979 (207 kilograms versus 159.4 kilograms).

D. Administrative separations declined by 25 percent since 1979. Selected unit urinalysis testing for company size units (SUUTCO) increased by 68 percent in 1980 versus 1979. Positive rate declined from 2.6 percent in 1979 to 1.8 percent in 1980.

E. Numbers of personnel in drug rehabilitation decreased by 31 percent in 1980 while the numbers of personnel in alcohol rehabilitation increased by 20 percent. Alcohol abuse constitutes the majority of ADAPCP cases.

F. Significant gains were made in countering drug abuse: (1) Number of personnel in drug rehabilitation declined; (2) New drug confirmations declined; (3) SUUTCO testing increased significantly while positive rate declined; (4) Marked gains in law enforcement efforts to combat drug offenders, (gains were partially offset by increases in alcohol abuse); and (5) Education of alcohol abusers will increase.

Overall, we believe that drug abuse within the European Command shows a gradual decreasing trend; however, our optimism is guarded. The increasing availability of narcotics, other dangerous drugs, and the increasing level of cocaine usage causes us concern.

Utilizing all methods of identification: surveys and commander estimates/identification, urinalysis testing, arrest/apprehensions, self-identification and incident to medical care, the best estimates of drug usage within USEUCOM are as follows:

Substance	USAREUR	USNAVEUR	USAFE	USEUCOM
Marijuana hashish	28	18	13	23
Cocaine	4	0.25	2	3
Heroin	3	(1)	1	2
Other opiates	2	1	0.25	1

---

[1] Negligible.

ASSISTANT SECRETARY OF DEFENSE, HEALTH AFFAIRS,
Washington, D.C., May 1, 1981.

MEMORANDUM FOR THE SECRETARY OF DEFENSE

Subject: Reply to Congressman Glenn English—Action memorandum.

You have received a letter (Tab B) from Congressman Glenn English, Chairman of the Task Force on Drug Abuse in the Military, HR Select Committee on Narcotics Abuse and Control, in which he asks for certain data relative to our drug abuse control program. Specifically, he requests a current report on the progress made in implementing twelve new drug abuse control initiatives (Tab C) announced by the Deputy Secretary of Defense, Charles W. Duncan, in Congressional testimony on 27 July 1978. He also requests an update assessment on the drug abuse situation in Europe.

We immediately began preparing the response to the twelve initiatives. However, they were not ready by the 17 April suspense date we were given nor was the Europe assessment ready by that time. A message was sent to EUCOM asking them to prepare the assessment and that information has now been received.

In view of the time required to prepare a proper answer it was believed advisable to provide Congressman English with an interim reply. Accordingly, a brief explanatory letter was prepared and sent (Tab D).

Now, all the information required to respond to Congressman English has been gathered and enclosed with a cover letter (Tab A). The enclosures to the letter address each of Mr. Duncan's initiatives, point by point, and provide an update on the situation in Europe since Congressman English's last visit there.

Recommend signature on the letter at Tab A.

JOHN H. MOXLEY III, M.D.

Mr. ADDABBO. I will accept a copy of them.

One final question. We have a vote and a few minutes to make it.

General Clarke, you have talked about the initiatives. The recent survey indicated that 40 percent of the first term soldiers used marihuana or hashish before they entered the service; 2 percent used hard drugs and another 10 percent used both.

Why are such personnel allowed into the service? Are you doing anything? Is anything being done to correct this situation so that we do not accept a user into the service because we also find that 80 percent of the current abusers were people who were users prior to coming into the service?

General CLARKE. Yes, sir; we have not had any type——

Mr. ZEFERETTI. Excuse me, General. I am going to have to stop because the vote ends at 2:23. We have like 3 minutes.

Could we just recess for about 5 minutes? We will come right back.

Admiral MULLOY. Mr. Chairman, will Mr. Addabbo come back?

Mr. ZEFERETTI. Yes, he is coming back.

[Recess.]

Mr. ZEFERETTI. You were responding?

General CLARKE. Yes, sir.

Mr. Addabbo, the Army authorizes limited or experimental preservice use of cannabis when we say that we allow it. It won't be a mandatory disqualification for enlistment or appointment in the Army.

However, dependence on marihuana or a court conviction or juvenile court adjudication for selling or trafficking in marihuana is a nonwaiverable disqualification for appointment or enlistment in the Army.

Any use of cannabis immediately preceding the application for the Army is disqualifying and a waiver will be required prior to enlistment.

Of course, the problem with that is that they can abstain for 90 days before they come in the Army and, of course, it will not be discovered.

However, we look to the future with a portable testing at the AFEES station. We hope that will assist us in identifying these personnel.

Mr. **Addabbo**. Are the recruiters fully aware of this? We know that recruiters are under tremendous pressure. There is tremendous competition. For all the service recruiters, remaining in place depends upon the number of recruits obtained. Has there been a possibility that the recruiters, in trying to meet their quota, has there been a tendency within the services to maintain the all volunteer service by looking the other way and saying well, maybe you are not a real user, you only use it occasionally, is that correct?

The guy having received a leading question, will say yes. He doesn't want to admit he is a user. Are any tests given?

General **Clarke**. No, sir, because we had none to test for cannabis up to this point.

Mr. **Addabbo**. Before his induction is he given a physical?

General **Clarke**. He is given a physical, yes.

Mr. **Addabbo**. As part of that physical, is a urinalysis made to determine whether or not drugs have been used?

General **Clarke**. Yes.

Mr. **Addabbo**. Is that——

General **Clarke**. But it will not show up cannabis.

Mr. **Addabbo**. Well, tests can determine now when the drug or drugs had been used, even marihuana, and possibly within what range of time.

If it showed that he has used the drug just within days of his test, would that be grounds for refusing his enlistment?

General **Clarke**. That would be up to the doctor, sir, to make that determination and to make the recommendation.

Mr. **Addabbo**. The doctor would determine that?

General **Clarke**. Whether or not he feels that the use—he is chronic or whether he just had a cigarette?

Mr. **Addabbo**. How——

General **Clarke**. The only way he can tell that is by asking the young man.

Mr. **Addabbo**. If the young man says, "I am not an addict, I was nervous, so I smoked just before I got here," so we now put him into the service and we find him as one of the statistics we have been reading about today, is that correct?

General **Clarke**. I would say that was possible, sir.

General **Louisell**. Could I help just a little bit?

We are proscribed by law from taking into the Armed Forces drug or alcohol dependent persons. Dependence, of course, means a very serious affliction. When an individual enters the Armed Forces and goes through the Armed Forces entrance and examining station, he is seen by a physician.

The motivation of people coming into the service is to get in. That, in turn, sets up a relationship between the doctor and the examinee, so the physician must be perceptive. If he has any doubts about the past drug history or alcohol history of the individual, the prospective enlistee is sent to a psychiatrist for a consultation. Between those two professionals they can make an assessment of that individual to find out if substance dependence does, in fact, disqualify him for entrance into the Armed Forces.

The ability to test for cannabis is coming onstream. There will perhaps be a time when we can afford to do that kind of testing at the Armed Forces entrance examining stations. However, with the high school class of 1980, for instance, one out of three using cannabis in the last 30 days, we are going to be very careful about how we apply our policies or we won't take anybody in.

Mr. ZEFERETTI. Will the gentleman yield to me? General, are you saying that we cannot perfect a kind of a rule that says that if you have been tested for substance abuse upon enlistment and found to be positive, that we will not accept you into the service?

Can't we make that kind of rule?

General LOUISELL. Sir, that is the rule.

Mr. ZEFERETTI. That is the rule?

General LOUISELL. That is the rule, but a waiver process is available.

Mr. ZEFERETTI. The waiver process is predicated solely on the testimony of the individual applicant coming in?

General LOUISELL. Well, that is not all that is there. Any public records regarding his past behavior, a consultation by the doctor, and if necessary a psychiatrist are available.

That protects the Armed Forces from the entrance of personalities who will be at such high risk that you can predict their failure in the military.

Mr. ZEFERETTI. What I am concerned about, if we are letting them slip in, if there is a way of letting them slip in, we are just—as Mr. Addabbo said earlier—we are just getting us another statistic and another problem for you to work with.

Maybe that is one area that we should attack in a different way and maybe look at differently and maybe find a solution for sort of weeding out those that would come in that way.

General LOUISELL. We are doing that, sir. We are looking at appropriate technology right now.

Mr. ZEFERETTI. Thank you.

General LOUISELL. I mentioned in my opening statement that the National Institute on Drug Abuse and the Department of Defense, are working together on a procedure which looks like it has promise. It can take a normal blood sample, as you would give in a routine physical examination and be able to detect alcoholism or drug dependence. How that is going to turn out, we don't know yet. It looks promising, but that is the best I could say about it.

When that occurs, it is going to be a very valuable tool. Taking blood in an entrance physical is very routine.

Mr. ENGLISH. General, wouldn't you agree that basically the people that we are keeping out that are not going to be eligible are going to be the guy that has been caught for pushing and the guy who is really physically dependent?

Now, the other fellow that is a recreational user, like you say, you have all kinds of high school kids out there to one degree or another that have experimented with drugs, particularly with pot, and that is not the person you are going to catch.

If he has been caught by the law, most likely he has been hit with a misdemeanor. You are not going to pick it up on his arrest record; isn't that correct?

General LOUISELL. Yes, sir, I think it is. I think I understand.

Mr. ENGLISH. The point I think I am trying to make—perhaps this is something that needs to be underscored time and time again—we are not talking about drug dependent people. That is not the problem. You have a very, very, very small percentage of people that would fit into that category either slipping into the service—and that is what they would be doing, slipping in undetected; somehow they manage to get by and it hasn't shown up on their record.

Or they have gotten into the service and perhaps have developed a problem. You are talking about way less than 1 percent of any of the services.

What you are really talking about, your problem is the guy that goes out here for recreational purposes and insists upon using drugs. He is doing it for the heck of it. You can give him all kinds of reasons as to why.

You can say he is bored, you can say he is living under stress, you can say he is unhappy, he is homesick, he is lovesick. Whatever his reasons, but the fact of the matter is, the bottom line is the guy has decided on his own he is doing it for the heck of it. He wants to do it.

He is not dependent upon anything. He doesn't have a craving for drugs. He is not an addict in any way. He has just decided to do it.

Now the real question that I see comes down to this: If you really are going to come down and say, Now look, friend, we are not going to tolerate drug abuse on duty, and if you get caught abusing drugs on duty, we are going to nail you.

We are going to bounce you out of the service, maybe, or even go—maybe you can give him one shot and say we are going to chalk that up to adolescence; two, we are going to nail you.

If that is the attitude you are going to take, the real problem you are going to come down to is who is going to break first? Is it going to be the All-Volunteer Force that is going to break or is it going to be this insistence upon using drugs recreationally? That is the real problem.

Because we are going to come down at some point to where we don't have enough soldiers to run the Army. That is what it is. I am not singling out the Army.

If that is the way these young people feel, if they insist on that recreational use, and we start getting tough and bouncing them out for on-duty use, the real question is whether they are going to give from the standpoint of ceasing to do it, getting the stuff off post and hopefully we would be able to do something about that.

It seems to me the No. 1 priority is that on-duty use right now. That has to be the target. Whether you are going to crack down and deal with that, and whether or not the All-Volunteer Force is going to survive doing it or whether we have to go to something else to give us enough manpower to be able to insist on that type of a policy.

I suppose I am making more of a statement. It started out a question, General, but any comment you want to make would be appreciated.

General LOUISELL. Sir, I agree that the No. 1 priority effort is on-duty use and abuse of substances.

Whatever the consequence may be to manning the force.

Mr. ADDABBO. General Louisell, General Clarke, others, an Army survey found that those people who used drugs before military service accounted for about 80 percent of the current marihuana abuse and 75 percent of the current hard drug abuse among first term soldiers.

This is not committee. This is Army. OK? This is your survey.

In view of that fact, in view of the litany I gave earlier in my opening statement about the numbers that we found about how many were being found near sophisticated weapons, near security posts, isn't it about time that the military changed their attitude and told the recruiters if there is a trace of drug use, we do not recruit that person?

Period, without psychiatrists, doctors, everything else?

In view of the fact that you found that 80 percent of those who are found after their first year are the abusers, isn't it about time we changed our attitude and said it is not acceptable; they are not acceptable? Anyone?

General CLARKE. I am sorry, sir.

You have me at a disadvantage with that 80 percent figure.

Mr. ADDABBO. This came out of the DOD study.

It is not a committee figure. This came out of the Burt study or rather the Army Human Readiness Report No. 5——

General CLARKE. Yes, sir. That report was, I believe, in 1976. That is a very old report.

Mr. ADDABBO. Has it changed?

General CLARKE. Yes, sir.

Mr. ADDABBO. How would you know?

General CLARKE. Sir?

Mr. ADDABBO. How would you know? Have you made further surveys?

General CLARKE. By the statistics we have here, sir.

Mr. ADDABBO. Burt's?

General CLARKE. Yes.

Mr. ADDABBO. How about the Burt study just made in 1980 which still proves different? How about the crash aboard the *Nimitz* in which we had 6 out of 14 dead showing drugs?

General LOUISELL. The DOD worldwide survey did not trace preinduction drug use and link it to performance after induction.

Mr. ADDABBO. Every year we get this testimony. Every year something is going to be done.

General Clarke, you just gave me a statement that that is an old report. You don't know if that holds true today.

The Army readiness report was not 1976. Here it is, August 1979. So it is not too old. It is not too old. So isn't it about time we start changing our attitude that it is not socially acceptable? That the recruiter must not meet his quota by taking into the services those who will not give us readiness?

Two hundred and twenty-two billion dollars will not buy us readiness if we have men and women who will not be able to handle those weapons because they are using drugs on duty.

Isn't it about time we changed our attitude?

General CLARKE. Sir, there is nothing wrong about the Army's attitude about drug abuse users. None at all. We agree with you wholeheartedly.

Mr. ADDABBO. Did I hear you right? Are you saying a drug user is not affecting readiness?

General CLARKE. I did not say that, sir. I said there is nothing wrong with my attitude about drug abuse.

Mr. ADDABBO. What is your attitude? Are they a threat to readiness? Is a drug abuser, a user on duty, a threat to readiness?

General CLARKE. You would have to tell me what you mean by a drug abuser. Are you talking about one——

Mr. ADDABBO. A person who just smoked a marihuana cigarette on duty near a nuclear weapon. Is he a threat to readiness?

General CLARKE. Well, I guess all I can say is that the Army doesn't approve of soldiers smoking on duty, marihuana.

Mr. ADDABBO. We don't approve. We just slap you on the hands. OK. Stand there. Be next to a nuclear weapon. Be a security officer. That is OK.

While you are there you can smoke marihuana. You are in the perfect service. That is why we have a problem, Mr. Chairman.

General CLARKE. Sir, those are your words, not mine.

Mr. ADDABBO. Yes, they are my words. They are the words of what I found with 6 out of the 14 dying aboard the crash on the *Nimitz*; what we find going aboard the *Forrestal*; what we find throughout the Army and the Navy. That is what we found. This is the problem.

You take $100 million out of the defense budget and say "We are taking care of the drug use" while we find statistic after statistic, men and women handling nuclear weapons in security positions being court martialed and everything because, why? Because you on the top accept it.

If you accept it, other officers beneath you accept it. If it is acceptable to them, it is acceptable to the private. If it is acceptable to the private, it is acceptable to everyone.

Where is readiness? It is down the drain; $222 billion from the American people because we do not have readiness. We have a service that is condoning, condoning drug use.

I have no further questions, Mr. Chairman.

Mr. ZEFERETTI. Thank you, Mr. Addabbo.

Admiral Mulloy, you said just before we broke to go down for the vote that there was something you wanted to explain or you wanted to——

Admiral MULLOY. Yes, sir, if I may.

Mr. Addabbo, as with the *Nimitz* accident, as you know, there is a two-track investigation system that occurs with aviation accidents. The mishap reporting procedures are confidential and privileged.

The Judge Advocate General investigation is currently in routing—in the case of the *Nimitz*, for example, it is at the tertiary level. The JAG level report will be released. I believe Admiral McDonald already assured you of that.

The same will be true of the *Kitty Hawk*.

Mr. ADDABBO. We have discussed it with the Secretary of the Navy. Reports will be made available to my committee and the staff.

Admiral MULLOY. Fine. I wanted to clarify that point. I could have been wrong on the record on that.

Mr. ZEFERETTI. Thank you. This will conclude the testimony for today.

Let me thank each of you for coming. Let me further state that the problem, as was indicated earlier, was pretty much reiterated by Mr. Addabbo as a real one.

It is something that we feel has to be addressed on a recruitment basis along with a kind of followthrough right through all phases of the service, with the kind of education and training and the kind of effort that is going to meet some real goals for the future.

We are here to lend our assistance toward that end, but to be quite frank we are a little bit dismayed as to taking or making reference to statistics rather than to programs and activities and the kinds of communication and intelligent exchanges that could be beneficial.

Again we are here to assist. We hope we can find in our search in society the kinds of programs and the kinds of intervention, ideas that we could ask you to duplicate or use as a means to combat this terrible condition that we have because it is terrible, whether it is 1 percent, and it is terrible whether it is 26 percent.

I think in fact if we are going to spend the kind of money we are going to spend in the national security of our Nation, then we have to make an investment in the young people that are given the responsibility of fulfilling their obligation to make us a secure Nation.

To do less than that, or to take a share of that dollar and make sure and to, if we have to, instill the kind of discipline and instill the kind of image of superiority, if we must, to produce that kind of individual that will be responsive and have combat readiness available for our armed services, then we have to do that too.

In other words, what I am trying to say is that we have to take every role and we have to make every effort to make sure that we are second to none in combat readiness and, more importantly, that we care about the very same people that we are asking to oblige us with that responsibility.

So I lend this committee's efforts to you for any way that you feel that we could help.

I would hope that we would have an open line of communication to follow through on the kind of programing and the kind of input that we think could be meaningful.

I thank you for taking your time and I thank you for your patience in going right through lunch and concluding this hearing today.

Thank you so very much.

General LOUISELL. Thank you, Mr. Chairman.

[Whereupon, at 2:50 p.m., the committee was adjourned.]

LEO C. ZEFERETTI, N.Y.
CHAIRMAN
PETER W. RODINO, JR., N.J.
CHARLES B. RANGEL, N.Y.
FORTNEY H. (PETE) STARK, CALIF.
GLENN ENGLISH, OKLA.
BILLY L. EVANS, GA.
JAMES H. SCHEUER, N.Y.
CARDISS COLLINS, ILL.
DANIEL K. AKAKA, HAWAII
FRANK J. GUARINI, N.J.
ROBERT T. MATSUI, CALIF.

EX OFFICIO:
MARIO BIAGGI, N.Y.
DANTE B. FASCELL, FLA.
LINDY BOGGS, LA.
BARBARA A. MIKULSKI, MD.
EARL HUTTO, FLA.
GEORGE DANIELSON, CALIF.
WALTER E. FAUNTROY, D.C.

U.S. House of Representatives
SELECT COMMITTEE ON
NARCOTICS ABUSE AND CONTROL
ROOM H2-234, HOUSE OFFICE BUILDING ANNEX 2
WASHINGTON, D.C. 20515

COMMITTEE PHONE 202-225-1753

TOM RAILSBACK, ILL.
RANKING MINORITY MEMBER
ROBIN L. BEARD, TENN.
BENJAMIN A. GILMAN, N.Y.
TENNYSON GUYER, OHIO
LAWRENCE COUGHLIN, PA.
ROBERT K. DORNAN, CALIF.
LAWRENCE J. DENARDIS, CONN.
E. CLAY SHAW, JR., FLA.

EX OFFICIO:
MATTHEW J. RINALDO, N.J.
ROBERT L. (BOB) LIVINGSTON, LA.
CHARLES F. DOUGHERTY, PA.
HENRY HYDE, ILL.

PATRICK L. CARPENTIER
CHIEF COUNSEL
ROSCOE B. STAREK III
MINORITY COUNSEL

September 10, 1981

Honorable Leo C. Zeferetti
Chairman
Select Committee on
  Narcotics Abuse and Control
H2-234, House Annex #2
Washington, DC 20515

Dear Mr. Chairman:

Enclosed is a compilation of the results of the Survey on the extent of drug abuse in the military. The Survey was conducted by the Task Force on Drug Abuse in the Military between June 26 and July 7, 1981, in cooperation with the House Armed Services Committee. The Survey was administered to 1,906 military personnel of all the Armed Services at installations in Italy and the Federal Republic of Germany. Also enclosed is a summary of the findings of the Task Force.

The Task Force conducted its survey at the U.S. Army installations which were previously surveyed by the Task Force in November, 1978. In addition, the 1981 Survey included U.S. Navy and U.S. Marine Corps personnel who were serving with the Mediterranean Fleet and at selected installations located in Naples, Italy. The Survey of 1981 also included a limited number of U.S. Air Force personnel serving in the Federal Republic of Germany.

Congressman Benjamin Gilman and I led the Survey Task Force. The following staff personnel also participated:

Patrick L. Carpentier, Chief Counsel
Roscoe B. Starek, III, Minority Counsel
Irving H. Soloway, Ph.D., Professional Staff
Elliott A. Brown, Professional Staff
James McDonald, Ph.D., Special Assistant to Congressman English
Donald Campbell, Professional Staff, Armed Services Committee

Sincerely,

GLENN ENGLISH
Co-Chairman
Task Force on Drug Abuse in the Military

GE:isn
Enclosures

LEO C. ZEFERETTI, N.Y.
CHAIRMAN
PETER W. RODINO, JR., N.J.
CHARLES B. RANGEL, N.Y.
FORTNEY H. (PETE) STARK, CALIF.
GLENN ENGLISH, OKLA.
BILLY L. EVANS, GA.
JAMES H. SCHEUER, N.Y.
CARDISS COLLINS, ILL.
DANIEL K. AKAKA, HAWAII
FRANK J. GUARINI, N.J.
ROBERT T. MATSUI, CALIF.

EX OFFICIO:
MARIO BIAGGI, N.Y.
DANTE B. FASCELL, FLA.
LINDY BOGGS, LA.
BARBARA A. MIKULSKI, MD.
EARL HUTTO, FLA.
GEORGE DANIELSON, CALIF.
WALTER E. FAUNTROY, D.C.

U.S. House of Representatives
SELECT COMMITTEE ON
NARCOTICS ABUSE AND CONTROL
ROOM H2-234, HOUSE OFFICE BUILDING ANNEX 2
WASHINGTON, D.C. 20515

COMMITTEE PHONE 202-225-1753

TOM RAILSBACK, ILL.
RANKING MINORITY MEMBER
ROBIN L. BEARD, TENN.
BENJAMIN A. GILMAN, N.Y.
TENNYSON GUYER, OHIO
LAWRENCE COUGHLIN, PA.
ROBERT K. DORNAN, CALIF.
LAWRENCE J. DENARDIS, CONN.
E. CLAY SHAW, JR., FLA.

EX OFFICIO:
MATTHEW J. RINALDO, N.J.
ROBERT L. (BOB) LIVINGSTON, LA.
CHARLES F. DOUGHERTY, PA.
HENRY HYDE, ILL.

PATRICK L. CARPENTIER
CHIEF COUNSEL
ROSCOE B. STAREK III
MINORITY COUNSEL

TASK FORCE ON DRUGS IN THE MILITARY

RESULTS:

PERSONAL DRUG USE SURVEY

STUDY MISSION

TO

ITALY AND THE FEDERAL REPUBLIC OF GERMANY

JUNE 26 - JULY 7, 1981

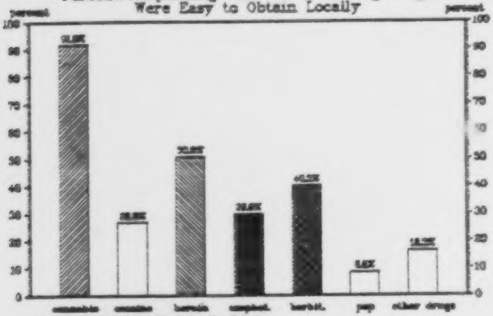
BACKGROUND: THE SELECT COMMITTEE'S SURVEY OF 1978

As a successor to the Select Committee's original drug abuse opinion survey administered DOD-wide from September, 1977 to February 1978, a second generation survey tool was developed for use by the Task Force on Drug Abuse in the Military while it was engaged in studying the drug abuse problem among U.S. Army personnel stationed in FRG. This instrument differed from the original in several respects. The most notable contrast was the insertion of questions designed to gather data on the respondents' personal drug use.

The questionnaire was administered during the period 14-17 November, 1978, by four teams of Task Force representatives at 12 locations throughout the Federal Republic of Germany (FRG). The sample of 626 was chosen on a random basis subject to availability considerations (making it an "opportunity sample"). Further, the targeted population was generally considered to be located in high-risk environments and to be at high-risk age (17-24 years old). Resource limitations precluded the possibility of constructing and administering a survey that would comply fully with accepted scientific sampling procedures. The purpose remained only to permit the Task Force to gain an impressionistic pattern of the substance picture in the FRG. The sample size of 626 was certainly not sufficiently large to allow extrapolation of the results to the entire E-1 to E-4 population in USAREUR and the Task Force does not maintain that this was a definitive and unchallengeable picture of the scope of the problem. The consistency of the results, however, indicated that the tool was sufficiently valid to identify the general scope of the problem and to give an idea of overall opinions and perceptions.

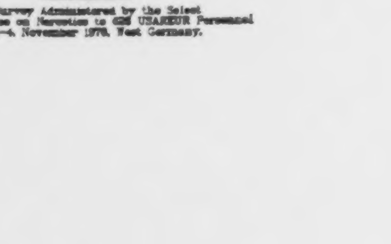
The material presented on the following pages outlines the results of the survey questionnaire administered by the Task Force on Drug Abuse in the Military.

Percent Responding That the Following Drugs Were Easy to Obtain Locally



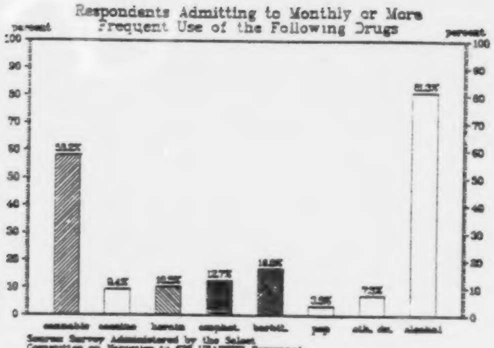
Source: Survey Administered by the Select Committee on Narcotics to [illegible] USAREUR Personnel 2-1 to 2-4 November 1978, West Germany.

Frequency of Alcohol Consumption



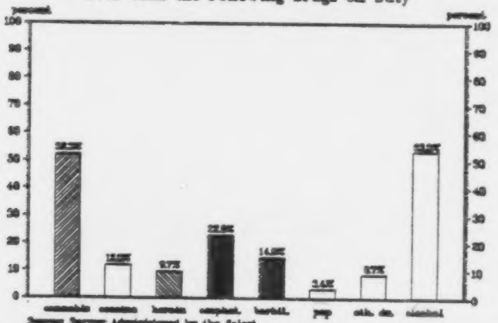
Source: Survey Administered by the Select Committee on Narcotics to [illegible] USAREUR Personnel 2-1 to 2-4 November 1978, West Germany.

Respondents Admitting to Monthly or More Frequent Use of the Following Drugs



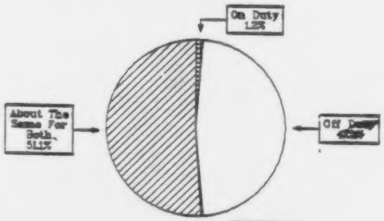
Source: Survey Administered by the Select Committee on Narcotics to [illegible] USAREUR Personnel E-1 to E-4, November 1978, West Germany.

Percentage of Respondents Admitting to Having Ever Used the Following Drugs On Duty



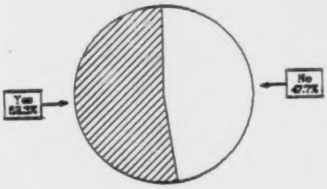
Source: Survey Administered by the Select Committee on Narcotics to [illegible] USAREUR Personnel E-1 to E-4, November 1978, West Germany.

When Drugs Are Used: On vs. Off Duty



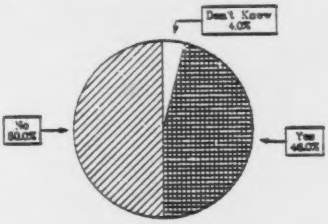
Source: Survey Administered by the Select Committee on Narcotics to [illegible] USAREUR Personnel E-1 to E-4, November 1978, West Germany.

Respondents Admitting to Having Used Cannabis On Duty



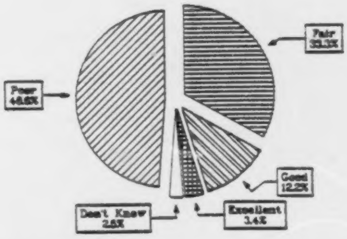
Source: Survey Administered by the Select
Committee on Narcotics to 628 USAREUR Personnel
E-1 to E-4, November 1978, West Germany.

Opinion: "Given the Amount of Drugs That Men-Women
In Your Unit Use, Do You Think They Could Go
Into Combat and Perform to the Best of Their Abilities?



Source: Survey Administered by the Select
Committee on Narcotics to 628 USAREUR Personnel
E-1 to E-4, November 1978, West Germany.

Evaluation of Army's Drug Treatment Program



Source: Survey Administered by the Select
Committee on Narcotics to 628 USAREUR Personnel
E-1 to E-4, November 1978, West Germany.

INTRODUCTION TO THE 1981 SURVEY

Following the Select Committee's Study Mission to the Federal Republic of Germany conducted by the Task Force on Drug Abuse in the Military in November of 1978, the Department of Defense initiated a major drug abuse prevention and control effort based upon its "Twelve Point Program."

As a follow-up to the Select Committee's mission of 1978, and to assess the effectiveness of the programs initiated by the Department of Defense, the Task Force on Drug Abuse in the Military conducted a Study Mission in June and July of 1981. In the 1981 study mission, the Task Force visited the same kasernes in West Germany that had been previously visited in 1978. In addition, the Task Force surveyed elements of the U.S. Naval Forces stationed with the Mediterranean Fleet, also including members of the U.S. Marine Corps.

The survey of 1981 was conducted under the leadership of Congressman Glenn English and Congressman Benjamin Gilman. The survey, as it concerned the Army, was basically the same as was conducted by the Select Committee's Task Force in 1978, except for the number of personnel surveyed. In 1978, 626 U.S. Army personnel stationed in West Germany were sampled. In 1981, 1036 U.S. Army personnel stationed in West Germany were sampled. Also, a small number of members of the U.S. Air Force stationed at Ramstein Air Force Base in West Germany were surveyed.

One thousand nine hundred and six (1,906) confidential questionnaires were completed by U.S. Armed Forces personnel. The questions ranged from perceptions of drug behavior; availability, and usage within units; degree of personal use and on-duty use of various drugs; an evaluation of the services' drug and alcohol treatment programs; and an evaluation of the effect of the perceived drug abuse in the respondents' units combat readiness.

The following chart details the locales and services represented in the 1981 survey population:

SURVEY SITES

SITE	SERVICE	NUMBER SURVEYED	PERCENT
USS FORRESTAL	NAVY	425	22.298%
USS FORRESTAL	MARINES	20	1.049%
USS PONCE	MARINES	98	5.142%
USS GUADALCANAL	MARINES	66	3.463%
USS GUADALCANAL	NAVY	37	1.941%
MARINE BARRACKS (NAPLES)	MARINES	38	1.994%
NAVAL SECURITY GRP	NAVY	28	1.469%
NAVAL REG MED CTR	NAVY	9	0.472%
NAVCAMSMED	NAVY	49	2.571%
ASCHAFFENBURG	ARMY	77	4.040%
BABENHAUSEN	ARMY	76	3.987%
BAD KREUZNACH	ARMY	74	3.882%
BAMBERG	ARMY	95	4.984%
BUDINGEN	ARMY	76	3.987%
HANAU	ARMY	83	4.355%
ESCHBORN	ARMY	50	2.623%
ILLESHEIM	ARMY	129	6.768%
MAINZ	ARMY	75	3.935%
NURNBERG-FURTH	ARMY	101	5.299%
WURZBURG	ARMY	101	5.299%
SCHWEINFURT	ARMY	99	5.194%
RAMSTEIN	AIR FORCE	100	5.247%
		1906	99.999%

ITALY	770	40.399%
FEDERAL REPUBLIC OF GERMANY	1136	59.601%
	1906	100.00%

SERVICE

ARMY	1036	54.355%
AIR FORCE	100	5.247%
MARINE CORPS	222	11.647%
NAVY	548	28.751%
	1906	100.00%

The survey of 1981 followed the methodology employed in the Select Committee's 1978 survey. The 1981 questionnaire was administered in Italy and West Germany by teams of Task Force representatives. The 1981 sample was chosen on a random basis according to subject availability considerations, making the survey sampling procedure not strictly random but an "opportunity sample." As in 1978, resource limitations precluded the possibility of constructing and administering a survey that would comply fully with accepted scientific sampling procedures. The purpose of both the 1978 and 1981 drug abuse surveys is only to permit the Select Committee on Narcotics Abuse and Control to develop an impressionistic appreciation of patterns of substance abuse among U.S. Armed Forces members in Western Europe. The Select Committee does not maintain that its survey is a definitive and unchallengeable statement on the scope of the substance abuse problem in the Armed Forces of the United States. The results of the survey do, however, display a good deal of consistency with other studies conducted by DoD and by the services in their respective efforts to assess the severity of the drug abuse problem within the U.S. Military. Hence, the survey of personal drug use which was administered by the Select Committee has validity in identifying the general scope of the problem.

TABLE #1 SELECTED SUMMARY DATA

RESPONDENTS (E-1 TO E-4) ADMITTING TO MONTHLY OR MORE FREQUENT USE OF THE FOLLOWING DRUGS:

	ARMY 1978	ARMY 1981	AIR FORCE 1981	MARINES 1981	NAVY 1981
MARIHUANA/ HASHISH	58.2%	52.57%	18.82%	40.42%	53.52%
COCAINE	9.4%	6.25%	3.61%	8.74%	8.78%
HEROIN	10.3%	4.05%	2.41%	1.10%	0.49%
UPPERS	12.7%	13.00%	5.95%	15.68%	31.88%
DOWNERS	16.9%	8.79%	3.57%	7.65%	13.14%
PCP	3.5%	2.12%	1.2%	1.11%	2.48%
OTHERS (LSD, PEYOTE,ETC)	7.3%	4.40%	2.43%	5.06%	10.22%
ALCOHOL	81.3%	73.40%	68.97%	78.65%	77.91%

TABLE #2

RESPONDENTS (E-1 TO E-4) ADMITTING TO WEEKLY OR MORE FREQUENT USE OF MARIHUANA/HASHISH

	DAILY		SEVERAL TIMES PER WEEK		ABOUT ONCE PER WEEK		TOTAL
ARMY 1978	16%	+	26.1%	+	9.4%	=	51.5%
ARMY 1981	16.14%	+	19.07%	+	11.98%	=	47.19%
AIR FORCE 1981	3.53%	+	4.71%	+	7.06%	=	15.3%
MARINES 1981	11.92%	+	16.06%	+	6.74%	=	34.72%
NAVY 1981	24.41%	+	17.61%	+	5.87%	=	47.89%

TABLE #3

CURRENT USE OF MARIHUANA/HASHISH BY NON-COMMISSIONED OFFICERS ***

	ARMY	(cumulative)	NAVY	(cumulative)
DAILY	15(9.2%)	9.2%	5 (4.42%)	4.42%
SEVERAL TIMES PER WEEK	21(12.88%)	22.08%	4 (3.54%)	7.96%
ONCE PER WEEK	9 (5.52%)	27.6%	8 (7.08%)	15.04%
ONCE PER MONTH	12(7.36%)	34.96%	4 (3.54%)	18.58%
LESS THAN ONCE PER MONTH	10(6.13%)	41.09%	11 (9.73%)	28.31%
DO NOT USE	96(58.9%)		81 (71.68%)	
TOTAL	163		113	
NO RESPONSE	6(3.55%)		2 (1.74%)	
RESPONSE RATE	96.45%		98.26%	

***At this point in the presentation of the survey results it is important to note that due to the realtively small numbers of Air Force and Marine Corps Non-Commissioned Officers who were surveyed, extreme caution is being taken with presenting compilations of their answers. The small numbers would both skew percentiles in a distorting manner and would likewise distort relationships between the answers given by the NCO's in the other services.

RESPONDENTS (E1-E4) ADMITTING TO USE OF COCAINE

	DAILY	SEVERAL TIMES PER WEEK	ABOUT ONCE PER WEEK	ABOUT ONCE PER MONTH	LESS THAN ONCE PER MONTH	TOTAL USE
ARMY 1981	.97%	1.11%	.83%	3.33%	7.77%	14.01%
MARINES 1981	1.09%	.546%	1.09%	6.01%	11.48%	20.216%
NAVY 1981	0.243%	0.49%	0.49%	7.56%	20.98%	29.763%

Cocaine appears to be used primarily as a purely recreational drug. Use of Cocaine once per week or more frequently is extremely small throughout the services and the ranks. However use of Cocaine once per month and less than once per month appear to indicate that Cocaine may very well be a "payday" drug - a substance which is used for purely recreational purposes. Reasons for this usage pattern are probably related to the mystique of cocaine's effects as well as its traditionally high price.

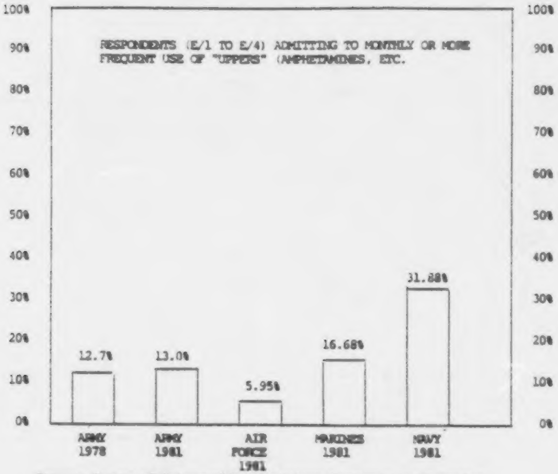
TABLE #4

TABLE #5

CURRENT USE OF "UPPERS" (AMPHETAMINES, ETC.) BY NON-COMMISSIONED OFFICERS (E-5 AND ABOVE).

	ARMY		NAVY	
		(Cumulative)		(Cumulative)
DAILY	1(0.66%)	0.66%	1 (.89%)	.89%
SEVERAL TIMES PER WEEK	1(.66%)	1.32%	2(1.79%)	2.68%
ABOUT ONCE PER WEEK	6(3.95%)	5.27%	1(.89%)	3.57%
ABOUT ONCE PER MONTH	5(3.29%)	8.56%	4(3.57%)	7.14%
LESS THAN ONCE PER MONTH	11(7.23%)	15.79%	6(5.36%)	12.5%
DO NOT USE	128(84.21%)		98(87.5%)	
TOTAL	152		112	
NO RESPONSE	17(10.06%)		3 (2.61%)	
RESPONSE RATE	89.44%		97.39%	

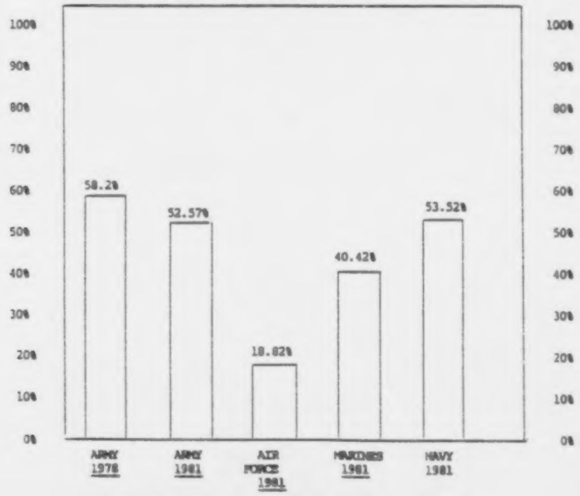
GRAPH #1


RESPONDENTS (E/1 TO E/4) ADMITTING TO MONTHLY OR MORE FREQUENT USE OF "UPPERS" (AMPHETAMINES, ETC.

Source: Survey administered by the Select Committee on Narcotics to 1906 U.S. Military Personnel (Italy and the Federal Republic of Germany) June-July, 1981

GRAPH #2

RESPONDENTS ADMITTING TO MONTHLY OR MORE FREQUENT USE OF MARIJUANA/HASHISH (E/1 TO E/4).



Source: Survey Administered by the Select Committee on Narcotics to 1906 U.S. Military Personnel (Italy and Federal Republic of Germany) June-July, 1981.

TABLE #6

USE OF DRUGS ON DUTY

USE OF ANY DRUG AND/OR ALCOHOL

ON DUTY (DURING WORKING HOURS)

IN THE LAST MONTH*

42.29% OF THE TOTAL SUBJECT POPULATION (1906 RESPONDENTS) ADMITTED USING DRUGS/ALCOHOL DURING THE MONTH PRECEDING THE ADMINISTERING OF THE SELECT COMMITTEE'S SURVEY

ARMY	42.66%	ADMITTED ON DUTY USE
AIR FORCE	17.00%	ADMITTED ON DUTY USE
MARINES	34.68%	ADMITTED ON DUTY USE
NAVY	49.27%	ADMITTED ON DUTY USE

TABLE #7

U.S.S. FORRESTAL

60.224% OF THE NAVY E-1 TO E-4 POPULATION SURVEYED ABOARD THE U.S.S. FORRESTAL ADMITTED USING DRUGS/ALCOHOL AT LEAST ONCE DURING THE MONTH PRECEDING THE ADMINISTERING OF THE SELECT COMMITTEE'S SURVEY

ON DUTY USAGE ABOARD THE FORRESTAL

52.4%	MARIHUANA/HASHISH ON DUTY
5.3%	COCAINE ON DUTY
36.13%	UPPERS ON DUTY
14.2%	DOWNERS ON DUTY
12.0%	OTHER DRUGS (LSD, PEYOTE, ETC.) ON DUTY
23.0%	ALCOHOL ON DUTY

*IN THE LAST MONTH PRECEDING ADMINISTERING OF THE SELECT COMMITTEE'S SURVEY QUESTIONNAIRE.

SUMMARY OF DATA

QUESTION: "DURING THE LAST MONTH, HAVE YOU USED ANY OF THE FOLLOWING WHILE ON DUTY (DURING WORKING HOURS)?"

(Percentages indicate affirmative answers)

	ARMY	AIR FORCE	MARINES	NAVY
MARIHUANA/HASHISH	38%	4.5%	24.34%	41.86%
COCAINE	3.03%	0	3.9%	3.82%
HEROIN	1.99%	0	0.55%	0.57%
UPPERS	9.6%	0	13.7%	27.05%
DOWNERS	4.56%	0	4.9%	10.13%
PCP	0.47%	0	0	0.19%
OTHER DRUGS (LSD, PEYOTE,ETC)	2.11%	0	2.2%	8.65%
ALCOHOL	28.01%	15.7%	19.4%	20.95%

***

USE OF THE FOLLOWING DRUGS ON DUTY BY ARMY PERSONNEL (1978 & 1981)

	1978	1981
MARIHUANA/HASHISH	52.3%	38%
COCAINE	12%	3.03%
HEROIN	9.7%	1.99%
UPPERS	22.9%	9.6%
DOWNERS	14.9%	4.56%
PCP	3.4%	0.47%
OTHER DRUGS	8.7%	2.11%
ALCOHOL	53.3%	28.01%

***

NOTE: The 1978 questionaire requested drug use on duty "ever" in the respondents memory. The 1981 survey requested on duty drug use data reflecting use on duty within the month preceding the survey. Extreme caution should be exercised in comparing the "on duty" use figures of 1978 and 1981.

TABLE #9

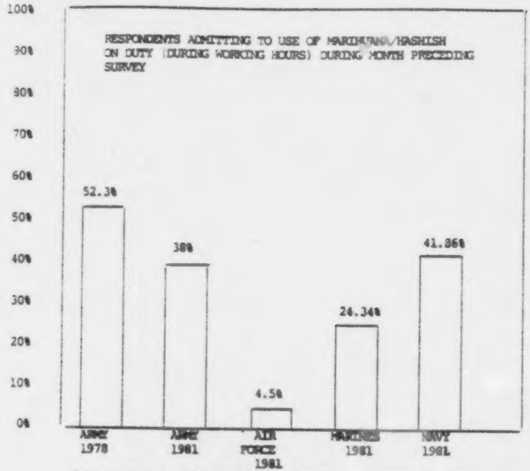
USE OF MARIHUANA/HASHISH OR ALCOHOL ON DUTY (DURING WORKINGS HOURS)

BY

NON-COMMISSIONED OFFICERS (E/5 AND ABOVE) IN MONTH PRECEDING SURVEY

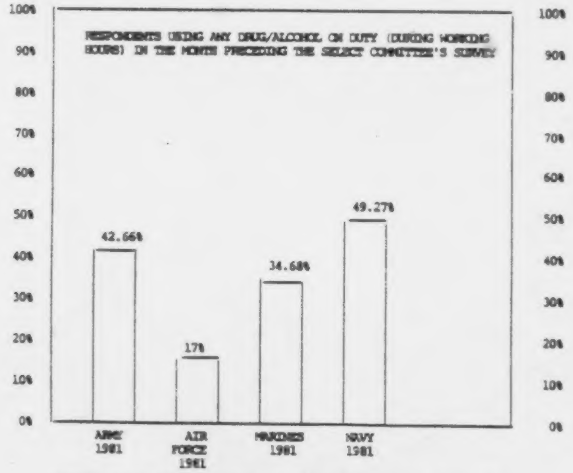
	ARMY	NAVY
MARIHUANA/HASHISH	25.5%	13%
ALCOHOL	24.6%	17%

GRAPH #3



Source: Survey administered by the Select Committee on Narcotics to 1906 U.S. Military Personnel (Italy and the Federal Republic of Germany) June-July, 1981

GRAPH #4



Source: Survey Administered by the Select Committee on Narcotics to 1906 U.S. Military Personnel (Italy and the Federal Republic of Germany) June-July, 1981

USE OF DRUGS AND ALCOHOL ON DUTY (DURING WORKING HOURS) BY SUBJECTS IN ARMY DRUG/ALCOHOL TREATMENT PROGRAMS AT TIME OF SURVEY.

	MARIHUANA/ HASHISH	COCAINE	HEROIN	DOWNERS	UPPERS	PCP	OTHERS	ALCOHOL
YES	20 (55.55%)	2 (6.06%)	1 (3.03%)	2 (6.06%)	6 (18.18%)	0	0	13 (38.24%)
NO	16 (44.44%	31 (93.94%)	32 (96.97%)	31 (93.94%)	27(81.82%)	33(100%)	33(100%)	21 (61.76%)
TOTAL	36	33	33	33	33	33	33	34
NO RESPONSE	2 (5.26%)	5 (13.16%)	5 (13.16%)	5 (13.16%)	5 (13.16%)	5(13.16%)	5(13.16%)	4 (10.53%)
RESPONSE RATE	94.74	86.84%	86.84%	86.84%	86.84%	86.84%	86.84%	89.47%

TABLE #10

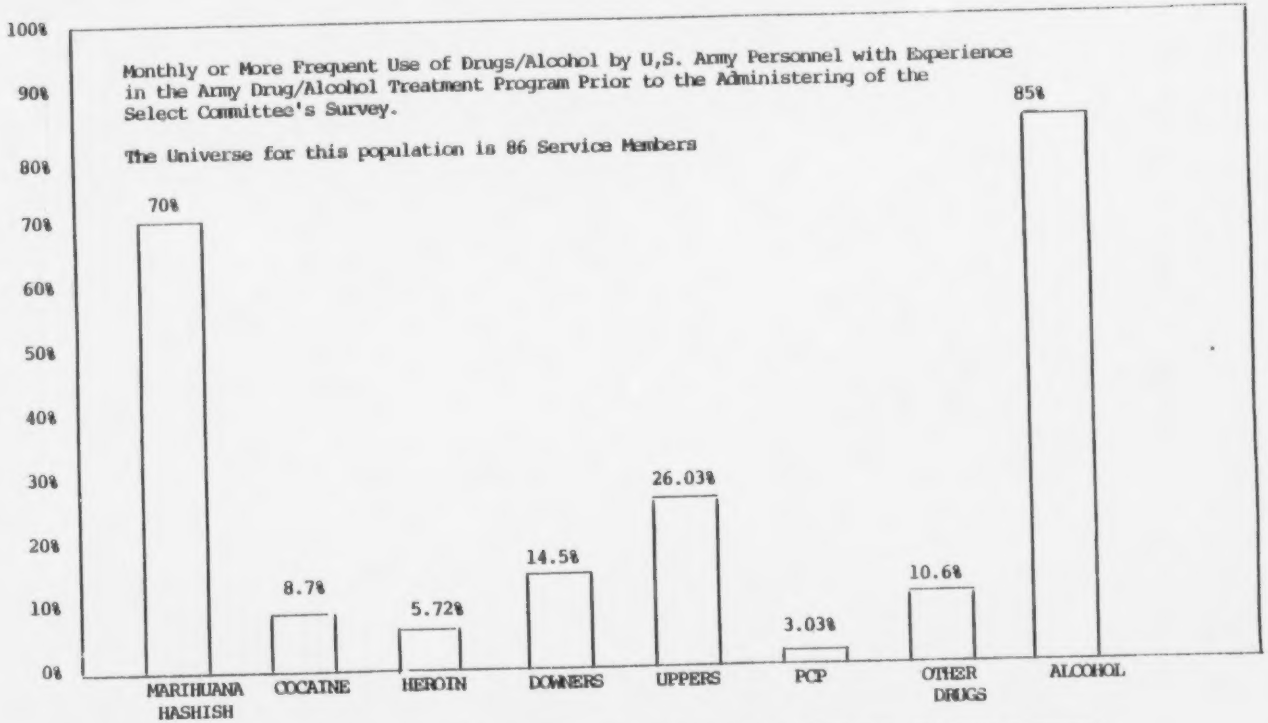
CURRENT USE OF DRUGS/ALCOHOL BY ARMY PERSONNEL WITH CURRENT OR PRIOR EXPERIENCE

IN THE ARMY DRUG/ALCOHOL TREATMENT PROGRAM: MONTHLY OR MORE FREQUENT USE

	MARIHUANA/ HASHISH	COCAINE	HEROIN	DOWNERS	UPPERS	PCP	OTHER	ALCOHOL
CURRENTLY IN TREATMENT	69.69%	7.69%	3.85%	15.39%	14.28%	8%	11.1%	76.66%
PRIOR TREATMENT EXPERIENCE	70%	8.7%	5.72%	14.5%	26.03%	3.03%	10.6%	85%

BASED UPON A UNIVERSE OF 33 CURRENT TREATMENT SUBJECTS AND 86 PRIOR TREATMENT SUBJECTS

TABLE #11



Monthly or More Frequent Use of Drugs/Alcohol by U,S. Army Personnel with Experience in the Army Drug/Alcohol Treatment Program Prior to the Administering of the Select Committee's Survey.

The Universe for this population is 86 Service Members

Source: Survey administered by the Select Committee on Narcotics to 1906 U.S. Military personnel (1,906) in Italy and the Federal Republic of Germany (June-July 1981)

GRAPH #5

DEMOGRAPHIC CHARACTERISTICS OF THE

SURVEY POPULATION

GRADE

	ARMY	AIR FORCE	MARINES	NAVY	TOTAL
E-1	60 (5.79%)	1 (1.0%)	13 (5.86%)	22 (4.01%)	96 (5.04%)
E-2	191 (18.44%)	10 (10%)	57 (25.68%)	80 (14.6%)	338 (17.73%)
E-3	219 (21.14%)	42 (42%)	93 (41.89%)	187 (34.12%)	541 (28.38%)
E-4	394 (38.03%)	35 (35%)	34 (15.32%)	144 (26.28%)	607 (31.85%)
OTHER	169 (16.31%)	12 (12%)	25 (11.26%)	115 (20.99%)	321 (16.84%)
NO RESPONSE	3 (0.29%)	0	0	0	3 (0.16%)
TOTAL	1036	100	222	548	1906 (100%)

AGE LAST BIRTHDAY

	ARMY	AIR FORCE	MARINES	NAVY	TOTAL
17-20	422 (40.73%)	33 (33%)	120 (54.05%)	191 (34.85%)	766 (40.19%)
21-23	350 (33.78%)	35 (35%)	76 (34.23%)	230 (41.97%)	691 (36.25%)
OVER 23	258 (24.90%)	32 (32%)	26 (11.71%)	127 (23.18%)	443 (23.24%)
NO RESPONSE	6 (0.58%)	0	0	0	6 (0.31%)
TOTAL	1036	100	222	548	1906 (100%)

LENGTH OF TIME IN SERVICE

	ARMY	AIR FORCE	MARINES	NAVY	TOTAL
LESS THAN ONE YEAR	235 (22.68%)	24 (24%)	43 (19.37%)	53 (9.67%)	355 (18.63%)
1 TO 2 YEARS	263 (25.39%)	25 (25%)	78 (35.14%)	167 (30.47%)	533 (27.96%)
OVER 2 YEARS	531 (51.25%)	51 (51%)	101 (45.49%)	326 (59.49%)	1009 (52.94%)
NO RESPONSE	7 (0.68%)	0	0	2 (0.36%)	9 (0.47%)
TOTAL	1036	100	222	548	1096 (100%)

TIME AT CURRENT DUTY STATION

	ARMY	AIR FORCE	MARINES	NAVY	TOTAL
LESS THAN ONE YEAR	457 (44.11%)	48 (48%)	102 (45.95%)	215 (39.23%)	822 (43.13%)
1 TO 2 YEARS	370 (35.71%)	39 (39%)	79 (35.58%)	192 (35.04%)	680 (35.68%)
OVER 2 YEARS	206 (19.88%)	13 (13%)	40 (18.02%)	141 (25.73%)	400 (20.99%)
NO RESPONSE	3 (0.29%)	0	1 (0.45%)	0	4 (0.20%)
TOTAL	1036	100	222	548	1906 (100%)

OPINIONS, PERCEPTIONS AND ATTITUDES OF THE
SURVEY POPULATION

QUESTION: "WHICH OF THE FOLLOWING DRUGS ARE EASY TO GET IN THIS AREA?"

(Percentage indicates affirmative answers per service population)

	MARIHUANA/ HASHISH	COCAINE	HEROIN	UPPERS	DOWNERS	PCP	OTHERS (LSD, ETC.)
ARMY (GERMANY)	.						
E-1 TO E-4 (1978)	91.8%	26.9%	50.9%	29.9%	40.3%	8.5%	16.3%
E-1 TO E-4 (1981)	91.09%	16.32%	19.1%	22.45%	20.25%	4.98%	12.5%
E-5 AND ABOVE (1981)	95.27%	25.44%	29.59%	30.18%	31.36%	8.28%	14.79%
AIR FORCE (GERMANY)							
E-1 TO E-4 (1981)	85.23%	17.05%	7.95%	22.73%	13.64%	4.55%	5.68%
E-5 AND ABOVE (1981)	91.67%	16.67%	8.33%	16.67%	25%	8.33%	8.33
MARINES (ITALY)							
E-1 TO E-4 (1981)	95.43%	18.78%	6.09%	25.89%	28.93%	4.06%	12.69%
E-5 AND ABOVE (1981)	80%	28%	16%	36%	28%	20%	25%
NAVY (ITALY)							
E-1 TO E-4 (1981)	96.77%	22.40%	7.39%	48.73%	39.03%	8.55%	21.94%
E-5 AND ABOVE (1981)	83.48%	16.52%	12.17%	37.39%	34.78%	7.83%	11.30%

QUESTION: "HOW MANY OF THE MEN/WOMEN IN YOUR UNIT USE EACH OF THE FOLLOWING MARIHUANA/HASHISH

THIS CHART REPRESENTS RESPONDENTS IN THE FOLLOWING GRADES E/1-E/4

	ARMY	AIR FORCE	MARINES	NAVY
NONE	22 (2.74%)	5 (6.67%)	4 (2.09%)	6 (1.43%)
A SMALL NUMBER 1-15%	94 (11.7%)	24 (32%)	38 (19.9%)	36 (8.61%)
LESS THAN HALF 16-40%	85 (10.59%)	26 (34.67%)	24 (12.56%)	39 (9.33%)
HALF 41-60%	136 (16.94%)	9 (12%)	34 (17.8%)	71 (17%)
MORE THAN HALF 61-80%	242 (30.14%)	9 (12%)	55 (28.79%)	153 (36.6%)
ALMOST ALL MORE THAN 81%	224 (27.89%)	2 (2.66%)	36 (18.85%)	113 (27.03%)
TOTAL	803	75	191	418
NO RESPONSE	61 (7.06%)	13 (14.77%)	6 (3.05%)	15 (3.46%)
RESPONSE RATE	92.94%	85.23%	96.95%	96.54%

QUESTION: "HOW MANY OF THE MEN/WOMEN IN YOUR UNIT USE EACH OF THE FOLLOWING MARIHUANA/HASHISH

THIS CHART REPRESENTS RESPONDENTS IN THE FOLLOWING GRADES E/5-6 ABOVE

	ARMY	AIR FORCE	MARINES	NAVY
NONE	3 (1.85%)	0	2 (9.09%)	6 (6.19%)
A SMALL NUMBER 1-15%	19 (11.73%)	3 (25%)	6 (27.27%)	20 (20.62%)
LESS THAN HALF 16-40%	28 (17.29%)	4 (33.33%)	3 (13.64%)	18 (18.56%)
HALF 41-60%	42 (25.92%)	4 (33.33%)	4 (18.18%)	20 (20.62%)
MORE THAN HALF 61-80%	41 (25.31%)	1 (8.33%)	5 (22.73%)	21 (21.65%)
ALMOST ALL MORE THAN 81%	29 (17.9%)	0	2 (9.09%)	12 (12.37%)
TOTAL	162	12	22	97
NO RESPONSE	7 (4.14%)	0	3 (12%)	18 (15.65%)
RESPONSE RATE	95.86%	100%	88%	84.35%

QUESTION: "HOW MANY OF THE MEN/WOMEN IN YOUR UNIT USE EACH OF THE FOLLOWING HEROIN

THIS CHART REPRESENTS RESPONDENTS IN THE FOLLOWING GRADES E/1 - E/4

	ARMY	AIR FORCE	MARINES	NAVY
NONE	259(47.87%)	48 (85.71%)	106(72.11%)	234 (70.91%)
A SMALL NUMBER 1-15%	205(37.89%)	8 (14.29%)	35 (23.8%)	91 (27.58%)
LESS THAN HALF 16-40% -	45 (8.32%)	0	4 (2.72%)	3 (.91%)
HALF 41-60%	15 (2.77%)	0	1 (.68%)	0
MORE THAN HALF 61-80%	12 (2.22%)	0	1 (.68%)	1 (.30%)
ALMOST ALL MORE THAN 81%	5 (.92%)	0	0	1 (.30%)
TOTAL	541	56	147	330
NO RESPONSE	323 (37.38%)	32 (36.36%)	50 (25.38%)	103 (23.79%)
RESPONSE RATE	62.62%	63.64%	74.62%	76.21%

QUESTION: "HOW MANY OF THE MEN/WOMEN IN YOUR UNIT USE EACH OF THE FOLLOWING HEROIN

THIS CHART REPRESENTS RESPONDENTS IN THE FOLLOWING GRADES E/5 & ABOVE

	ARMY	AIR FORCE	MARINES	NAVY
NONE	55 (44.35%)	4 (57.14%)	10 (58.82%)	57 (77.03%)
A SMALL NUMBER 1-15%	55 (44.35%)	2 (28.57%)	5 (29.41%)	16 (21.62%)
LESS THAN HALF 16-40%	9 (7.26%)	1 (14.29%)	1 (5.88%)	1 (1.35%)
HALF 41-60%	3 (2.42%)	0	0	0
MORE THAN HALF 61-80%	0	0	1 (5.88%)	0
ALMOST ALL MORE THAN 81%	2 (1.61%)	0	0	0
TOTAL	124	7	17	74
NO RESPONSE	45 (26.63%)	5 (41.67%)	8 (32%)	41 (35.65%)
RESPONSE RATE	73.37%	58.33%	68%	64.35%

QUESTION: "HOW MANY OF THE MEN/WOMEN IN YOUR UNIT USE EACH OF THE FOLLOWING COCAINE

THIS CHART REPRESENTS RESPONDENTS IN THE FOLLOWING GRADES E/1 - E/4

	ARMY	AIR FORCE	MARINES	NAVY
NONE	170 (31.42%)	29 (49.15%)	41 (26.28%)	45 (13.04%)
A SMALL NUMBER 1-15%	209 (38.63%	23 (39%)	66 (42.31%)	128 (37.1%)
LESS THAN HALF 16-40%	75 (13.86%)	5 (8.47%)	31 (19.87%)	105 (30.43%)
HALF 41-60%	57 (10.54%)	1 (1.69%)	12 (7.7%)	36 (10.43%)
MORE THAN HALF 61-80%	17 (3.14%)	1 (1.69%)	4 (2.56%)	23 (6.67%)
ALMOST ALL MORE THAN 81%	13 (2.4%)	0	2 (1.28%)	8 (2.32%)
TOTAL	541	59	156	345
NO RESPONSE	323 (37.38%)	29 (32.95%)	41 (20.81%)	88 (20.32%)
RESPONSE RATE	62.62%	67.05%	79.19%	79.68%

QUESTION: "HOW MANY OF THE MEN/WOMEN IN YOUR UNIT USE EACH OF THE FOLLOWING COCAINE

THIS CHART REPRESENTS RESPONDENTS IN THE FOLLOWING GRADES E/5 & ABOVE

	ARMY	AIR FORCE	MARINES	NAVY
NONE	32 (26.67%)	2 (28.57%)	4 (22.22%)	29 (38.67%)
A SMALL NUMBER 1-15%	54 (45%)	4 (57.14%)	8 (44.44%)	31 (41.33%)
LESS THAN HALF 16-40%	25 (20.83%)	0	4 (22.22%)	9 (12%)
HALF 41-60%	6 (5%)	1 (14.29%)	1 (5.56%)	3 (4%)
MORE THAN HALF 61-80%	1 (.83%)	0	1 (5.56%)	3 (4%)
ALMOST ALL MORE THAN 81%	2 (1.67%)	0	0	0
TOTAL	120	7	18	75
NO RESPONSE	49 (28.99%)	5 (41.67%)	7 (28%)	40 (34.78%)
RESPONSE RATE	71.01%	58.33%	72%	65.22%

QUESTION: "HOW MANY OF THE MEN/WOMEN IN YOUR UNIT USE EACH OF THE FOLLOWING "DOWNERS" (Barbiturates, tranquilizers, etc.)

THIS CHART REPRESENTS RESPONDENTS IN THE FOLLOWING GRADES E/1 - E/4

	ARMY	AIR FORCE	MARINES	NAVY
NONE	155 (28.23%)	34 (60.71%)	44 (27.85%)	54 (15.51%
A SMALL NUMBER 1-15%	202 (36.79%)	14 (25%)	61 (38.61%)	96 (27.59%)
LESS THAN HALF 16-40%	101 (18.4%)	5 (8.93%)	24 (15.19%)	92 (26.44%)
HALF 41-60%	48 (8.74%)	2 (3.57%)	18 (11.39%)	62 (17.81%)
MORE THAN HALF 61-80%	34 (6.2%)	1 (1.79%)	4 (2.53%)	31 (8.91%)
ALMOST ALL MORE THAN 81%	9 (1.64%)	0	7 (4.43%)	13 (3.73%)
TOTAL	549	56	158	348
NO RESPONSE	315 (36.46%)	32 (36.36%)	39 (19.8%)	85 (19.63%)
RESPONSE RATE	63.54%	63.64%	80.2%	80.37%

QUESTION: "HOW MANY OF THE MEN/WOMEN IN YOUR UNIT USE EACH OF THE FOLLOWING "Downers" (Barbiturates, tranquilizers, etc.)

THIS CHART REPRESENTS RESPONDENTS IN THE FOLLOWING GRADES E-5 & ABOVE

	ARMY	AIR FORCE	MARINES	NAVY
NONE	21 (17.21%)	4 (57.14%)	4 (23.53%)	30 (35.29%)
A SMALL NUMBER 1-15%	57 (46.72%)	2 (28.57%)	8 (47.06%)	28 (32.94%)
LESS THAN HALF 16-40%	22 (18.03%)	1 (14.29%)	3 (17.65%)	18 (21.18%)
HALF 41-60%	15 (12.3%)	0	1 (5.88%)	5 (5.88%)
MORE THAN HALF 61-80%	3 (2.46%)	0	1 (5.88%)	3 (3.53%)
ALMOST ALL MORE THAN 81%	4 (3.28%)	0	0	1 (1.18%)
TOTAL	122	7	17	85
NO RESPONSE	47 (27.81%)	5 (41.67%)	8 (32%)	30 (26.09%)
RESPONSE RATE	72.19%	58.33%	68%	73.91%

QUESTION: "HOW MANY OF THE MEN/WOMEN IN YOUR UNIT USE EACH OF THE
FOLLOWING "Uppers" (Amphetamines, other stimulants, etc.)

THIS CHART REPRESENTS RESPONDENTS IN THE FOLLOWING GRADES E/1 - E/4

	ARMY	AIR FORCE	MARINES	NAVY
NONE	108 (19.18%)	24 (40.68%)	33 (20.12%)	27 (7.22%)
A SMALL NUMBER 1-15%	194 (34.46%)	22 (37.29%)	59 (35.97%)	65 (17.38%)
LESS THAN HALF 16-40%	110 (19.54%)	8 (13.56%)	32 (19.51%)	82 (21.92%)
HALF 41-60%	77 (13.68%)	2 (3.38%)	19 (11.59%)	85 (22.73%)
MORE THAN HALF 61-80%	54 (9.59%)	2 (3.38%)	13 (7.93%)	74 (19.79%)
ALMOST ALL MORE THAN 81%	20 (3.55%)	1 (1.69%)	8 (4.88%)	41 (10.96%)
TOTAL	563	59	164	374
NO RESPONSE	301 (34.84%)	29 (32.95%)	33 (16.75%)	59 (13.63%)
RESPONSE RATE	65.16%	67.05%	83.25%	86.37%

QUESTION: "HOW MANY OF THE MEN/WOMEN IN YOUR UNIT USE EACH OF THE FOLLOWING "UPPERS" (Amphetamines, other stimulants, etc.)

THIS CHART REPRESENTS RESPONDENTS IN THE FOLLOWING GRADES E/5 & ABOVE

	ARMY	AIR FORCE	MARINES	NAVY
NONE	22 (17.74%)	3 (42.86%)	4 (23.53%)	22 (25.58%)
A SMALL NUMBER 1-15%	48 (38.71%)	3 (42.86%)	5 (29.41%)	21 (24.42%)
LESS THAN HALF 16-40%	25 (20.16%)	1 (14.28%)	4 (23.53%)	21 (24.42%)
HALF 41-60%	15 (12.10%)	0	3 (17.65%)	12 (13.95%)
MORE THAN HALF 61-80%	10 (8.06%)	0	1 (5.88%)	8 (9.3%)
ALMOST ALL MORE THAN 81%	4 (3.23%)	0	0	2 (2.33%)
TOTAL	124	7	17	86
NO RESPONSE	45 (26.63%)	5 (41.67%)	8 (32%)	29 (25.22%)
RESPONSE RATE	73.37%	58.33%	68%	74.78%

QUESTION: "HOW MANY OF THE MEN/WOMEN IN YOUR UNIT USE EACH OF THE FOLLOWING PCP

THIS CHART REPRESENTS RESPONDENTS IN THE FOLLOWING GRADES E/1 - E/4

	ARMY	AIR FORCE	MARINES	NAVY
NONE	313 (63.1%)	45 (81.82%)	84 (59.15%)	162 (51.43%)
A SMALL NUMBER 1-15%	135 (27.22%)	8 (14.54%)	47 (33.1%)	102 (32.38%)
LESS THAN HALF 16-40%	23 (4.64%)	2 (3.64%)	6 (4.23%)	32 (10.16%)
HALF 41-60%	13 (2.62%)	0	3 (2.11%)	8 (2.54%)
MORE THAN HALF 61-80%	9 (1.81%)	0	2 (1.41%)	7 (2.22%)
ALMOST ALL MORE THAN 81%	3 (.60%)	0	0	4 (1.27%)
TOTAL	496	55	142	315
NO RESPONSE	368 (42.59%)	33(37.5%)	55 (27.92%)	118 (27.25%)
RESPONSE RATE	57.41%	62.5%	72.08%	72.75%

QUESTION: "HOW MANY OF THE MEN/WOMEN IN YOUR UNIT USE EACH OF THE FOLLOWING PCP

THIS CHART REPRESENTS RESPONDENTS IN THE FOLLOWING GRADES E/5 & ABOVE

	ARMY	AIR FORCE	MARINES	NAVY
NONE	58 (55.24%)	5 (71.43%)	7 (41.18%)	49 (65.33%)
A SMALL NUMBER 1-15%	36 (34.29%)	2 (28.57%)	8 (47.06%)	19 (25.33%)
LESS THAN HALF 16-40%	5 (4.76%)	0	1 (5.88%)	3 (4%)
HALF 41-60%	4 (3.81%)	0	1 (5.88%)	3 (4%)
MORE THAN HALF 61-80%	1 (0.95%)	0	0	1 (1.33%)
ALMOST ALL MORE THAN 81%	1 (0.95%)	0	0	0
TOTAL	105	7	17	75
NO RESPONSE	64 (37.87%)	5 (41.67%)	8 (32%)	40 (34.78%)
RESPONSE RATE	62.13%	58.33%	68%	65.22%

QUESTION: "HOW MANY OF THE MEN/WOMEN IN YOUR UNIT USE EACH OF THE FOLLOWING Other Drugs (LSD, Peyote, etc)

THIS CHART REPRESENTS RESPONDENTS IN THE FOLLOWING GRADES E/1 - E/4

	ARMY	AIR FORCE	MARINES	NAVY
NONE	213 (44.1%)	40 (78.43%)	68 (48.92%)	97 (30.5%)
A SMALL NUMBER 1-15%	157 (32.51%)	11 (21.57%)	42 (30.21%)	91 (28.62%)
LESS THAN HALF 16-40%	46 (9.52%)	0	14 (10.07%)	60 (18.87%)
HALF 41-60%	34 (7.04%)	0	7 (5.04%)	39 (12.26%)
MORE THAN HALF 61-80%	22 (4.55%)	0	4 (2.88%)	18 (5.66%)
ALMOST ALL MORE THAN 81%	11 (2.28%)	0	4 (2.88%)	13 (4.09%)
TOTAL	483	51	139	318
NO RESPONSE	381 (44.1%)	37 (42.05%)	58 (29.44%)	115 (26.56%)
RESPONSE RATE	55.9%	57.95%	70.56%	73.44%

QUESTION: "HOW MANY OF THE MEN/WOMEN IN YOUR UNIT USE EACH OF THE FOLLOWING OTHER DRUGS (LSD, Peyote, etc)

THIS CHART REPRESENTS RESPONDENTS IN THE FOLLOWING GRADES E/5 & ABOVE

	ARMY	AIR FORCE	MARINES	NAVY
NONE	42 (42.42%)	4 (57.1%)	8 (47.06%)	41 (59.42%)
A SMALL NUMBER 1-15%	40 (40.4%)	1 (14.3%)	8 (47.06%)	20 (28.99%)
LESS THAN HALF 16-40%	6 (6.06%)	1 (14.3%)	1 (5.88%)	5 (7.25%)
HALF 41-60%	7 (7.07%)	0	0	2 (2.89%)
MORE THAN HALF 61-80%	2 (2.02%)	1 (14.3%)	0	1 (1.45%)
ALMOST ALL MORE THAN 81%	2 (2.02%)	0	0	0
TOTAL	99	7	17	69
NO RESPONSE	70 (41.42%)	5 (41.67%)	8 (32%)	46 (40%)
RESPONSE RATE	58.58%	58.33%	68%	60%

QUESTION: "DO SOLDIERS IN YOU UNIT FREQUENTLY USE BEER, WINE OR HARD LIQUOR WITH THE DRUGS MENTIONED IN QUESTION 6?" (Marihuana/Hashish, Heroin, Cocaine, "Downers", "Uppers", PCP, Other Drugs)

E-1 TO E-4

	ARMY	AIR FORCE	MARINES	NAVY
YES	690(84.98%)	58 (73.42%	144 (75.79%)	327 (79.95%)
NO	122(15.02%)	21 (26.58%)	46 (24.21%)	82 (20.05%)
TOTAL	812	79	190	409
NO RESPONSE	52(6.02%)	9 (10.23%)	7 (3.55%)	24 (5.54%)
RESPONSE RATE	93.98%	89.77%	96.45%	94.46%

E-5 AND ABOVE

	ARMY	AIR FORCE	MARINES	NAVY
YES	143(88.82%)	7 (70%)	16 (84.21%)	69 (73.4%)
NO	18(11.18%)	3 (30%)	3 (15.79%)	25 (26.6%)
TOTAL	161	10	19	94
NO RESPONSE	8(4.73%)	2 (16.67%)	6 (24%)	21 (18.26%)
RESPONSE RATE	95.27%	83.33%	76%	81.74%

QUESTION: "WHEN DRUGS ARE USED TO GET HIGH, THEY ARE MORE FREQUENTLY USED (ON BASE) (OFF BASE) (ABOUT THE SAME FOR BOTH)."

	ARMY	AIR FORCE	MARINES	NAVY
ON BASE	173 (17.53%)	6 (7.06%)	10 (4.74%)	44 (8.48%)
OFF BASE	135 (13.67%)	28 (32.94%)	71 (33.65%)	172 (33.14%)
ABOUT THE SAME FOR BOTH	679 (68.8%)	51 (60%)	130 (61.61%)	303 (58.38%)
NO RESPONSE	49 (4.73%)	15 (15%)	11 (4.95%)	29 (5.29%)
TOTAL	1036	100	222	548

RESPONSE RATE TO QUESTION:

95.27% OF TOTAL ARMY SUBJECTS RESPONDED TO QUESTION(987 RESPONDED)

85% OF TOTAL AIR FORCE SUBJECTS RESPONDED TO QUESTION(85 RESPONDED)

95,05% OF TOTAL MARINE SUBJECTS RESPONDED TO QUESTION (211 RESPONDED)

94.71% OF TOTAL NAVY SUBJECTS RESPONDED TO QUESTION (519 RESPONDED)

QUESTION: "WHEN ARE DRUGS MORE OFTEN USED?"
(ON DUTY) (OFF DUTY) (ABOUT THE SAME FOR BOTH)

	ARMY	AIR FORCE	MARINES	NAVY
ON DUTY (WORK HOURS)	29(2.91%)	0	1 (0.47%)	20 (3.81%)
OFF DUTY	605(60.68%)	81 (93.1%)	165(76.74%)	301 (57.33%)
ABOUT THE SAME FOR BOTH	363(36.41%)	6 (6.9%)	49(22.79%)	204 (38.86%)
NO RESPONSE	39 (3.76%)	13 (13%)	7 (3.15%)	23 (4.2%)
TOTAL	1036	100	222	548

RESPONSE RATE TO QUESTION:

96.24% OF TOTAL ARMY SUBJECTS RESPONDED TO QUESTION(997 RESPONSES)

87% OF TOTAL AIR FORCE SUBJECTS RESPONDED TO QUESTION(87 RESPONSES)

96.85% OF TOTAL MARINE SUBJECTS RESPONDED TO QUESTION(215 RESPONSES)

95.8% OF TOTAL NAVY SUBJECTS RESPONDED TO QUESTION(525 RESPONSES)

QUESTION: "DRUGS ARE MOST FREQUENTLY USED (ON WEEKENDS) (ON WEEKDAYS) (ABOUT THE SAME FOR BOTH)

	ARMY	AIR FORCE	MARINES	NAVY
WEEKENDS	295(29.65%)	35 (41.18%)	72(33.49%)	102 (19.58%)
WEEKDAYS	51 (5.13%)	1 (1.18%)	9 (4.19%)	21 (4.03%)
ABOUT THE SAME FOR BOTH	649(65.22%)	49 (57.64%)	134(62.32%)	398 (76.39%)
NO RESPONSE	41 (3.96%)	15 (15%)	7 (3.15%)	27 (4.93%)
TOTAL	1036	100	222	548

RESPONSE RATE TO QUESTION:

96.04% OF TOTAL ARMY SUBJECTS RESPONDED TO QUESTION (995 RESPONSES)

85% OF TOTAL AIR FORCE SUBJECTS RESPONDED TO QUESTION(85 RESPONSES)

96.85% OF TOTAL MARINE SUBJECTS RESPONDED TO QUESTION(215 RESPONSES)

95.07% OF TOTAL NAVY SUBJECTS RESPONDED TO QUESTION (521 RESPONSES)

QUESTION: "GIVEN THE AMOUNT OF DRUGS THAT MEN/WOMEN IN YOUR UNIT USE, DO YOU THINK THEY COULD GO INTO COMBAT AND PERFORM TO THE BEST OF THEIR ABILITIES?"

E-1 TO E-4

	ARMY	AIR FORCE	MARINES	NAVY
YES	449(56.91%)	47 (58.75%)	102 (54.84%)	257 (61.48%)
NO	340(43.09%)	33 (41.25%)	84 (45.16%)	161 (38.52%)
TOTAL	789	80	186	418
NO RESPONSE	75 (8.68%)	8 (9.09%)	11 (5.58%)	15 (3.46%)
RESPONSE RATE	91.32%	90.91%	94.42%	96.54%

E-5 AND ABOVE

	ARMY	AIR FORCE	MARINES	NAVY
YES	72 (46.75%)	8 (72.73%)	8 (40%)	50 (48.08%)
NO	82 (53.25%)	3 (27.27%)	12 (60%)	54 (51.92%)
TOTAL	154	11	20	104
NO RESPONSE	15 (8.88%)	1 (8.33%)	5 (20%)	11 (9.57%)
RESPONSE RATE	91.12%	91.67%	80%	90.43%

CURRENT DRUG USE

QUESTION: "HOW OFTEN DO YOU NOW USE EACH OF THE FOLLOWING?"
THIS TABLE REPRESENTS PERSONAL MARIHUANA/HASHISH USE

	ARMY		AIR FORCE		MARINES		NAVY	
		Cumulative		Cumulative		Cumulative		Cumulative
DAILY	147(14.97%)	14.97%	3 (3.125%	3.125%	26(12.09%)	12.09%	109(20.22%)	20.22%
SEVERAL TIMES PER WEEK	177 (18.02%)	32.99%	4 (4.17%)	7.295%	32(14.88%)	26.97%	79(14.66%)	34.88%
ABOUT ONCE A WEEK	107 (10.9%)	43.89%	6 (6.25%)	13.545%	15(6.98%)	33.95%	33 (6.12%)	41%
ABOUT ONCE A MONTH	56 (5.7%)	49.59%	3(3.125%)	16.67%	11 (5.12%)	39.07%	28 (5.19%)	46.19%
LESS THAN ONCE A MONTH	76 (7.74%)	57.33%	6 (6.25%)	22.92%	25(11.63%)	50.7%	59 (10.95%)	57.14%
DO NOT USE	419(42.67%)		74 (77.08%)		106(49.3%)		231(42.86%)	
TOTAL	982		96		215		539	
NO ANSWER	54(5.21%)		4 (4%)		7 (3.15%)		9 (1.64%)	
RESPONSE RATE	94.79%		96%		96.85%		98.36%	

QUESTION: "HOW OFTEN DO YOU NOW USE EACH OF THE FOLLOWING?"
THIS TABLE REPRESENTS PERSONAL COCAINE USE

	ARMY		AIR FORCE		MARINES		NAVY	
		Cumulative		Cumulative		Cumulative		Cumulative
DAILY	8 (0.92%)	0.92%	2 (2.13%)	2.13%	2 (0.98%)	0.98%	1 (0.19%)	0.19%
SEVERAL TIMES PER WEEK	8 (0.92%)	1.84%	0	2.13%	2 (0.98%)	1.96%	3 (0.58%)	0.77%
ABOUT ONCE A WEEK	8 (0.92%)	2.76%	1 (1.06%)	3.19%	2 (0.98%)	2.94%	2 (0.39%)	1.16%
ABOUT ONCE A MONTH	25 (2.87%)	5.63%	0	3.19%	11 (5.36%)	8.23%	32 (6.17%)	7.33%
LESS THAN ONCE A MONTH	65(7.46%)	13.09%	3 (3.19%)	6.38%	23 (11.21%)	19.51%	89 (17.15%)	24.48%
DO NOT USE	757(86.91%)		88 (93.62%)		165(80.49%)		392(75.52%)	
TOTAL	871		94		205		519	
NO ANSWER	165 (15.93%)		6 (6%)		17 (7.66%)		29 (5.29%)	
RESPONSE RATE	84.07%		94%		92.34%		94.71%	

QUESTION: "HOW OFTEN DO YOU NOW USE EACH OF THE FOLLOWING?"
THIS TABLE REPRESENTS PERSONAL HEROIN USE

	ARMY	Cumulative	AIR FORCE	Cumulative	MARINES	Cumulative	NAVY	Cumulative
DAILY	6 (0.69%)	0.69%	1 (1.06%)	1.06%	1 (0.49%)	0.49%	0	0%
SEVERAL TIMES PER WEEK	6 (0.69%)	1.38%	0	1.06%	1 (0.49%)	0.98%	0	0%
ABOUT ONCE A WEEK	2 (0.23%)	1.61%	1 (1.06%)	2.12%	0	0.98%	0	0%
ABOUT ONCE A MONTH	19 (2.19%)	3.8%	0	2,12%	1 (0.49%)	1.47%	2 (0.38%)	0.38%
LESS THAN ONCE A MONTH	17 (1.96%)	5.76%	0	2.12%	3 (1.48%)	2.95%	10 (1.93%)	2.31%
DO NOT USE	818 (94.24%)		92(97.87%)		197(97.04%)		507 (97.69%)	
TOTAL	868		94		203		519	
NO ANSWER	168(16.22%)		6 (6%)		19 (8.56%		29(5.29%)	
RESPONSE RATE	83.78%		94%		91.44%		94.71%	

QUESTION: "HOW OFTEN DO YOU NOW USE EACH OF THE FOLLOWING?"
THIS TABLE REPRESENTS PERSONAL "DOWNER"* USE

	ARMY		AIR FORCE		MARINES		NAVY	
		Cumulative		Cumulative		Cumulative		Cumulative
DAILY	12 (1.38%)	1.38%	1 (1.05%)	1.05%	2 (0.97%)	0.97%	3(0.58%)	0.58%
SEVERAL TIMES PER WEEK	17 (1.96%)	3.34%	2 (2.11%)	3.16%	1 (0.49%)	1.46%	6 (1.15%)	1.73%
ABOUT ONCE A WEEK	16 (1.84%)	5.18%	0	3.16%	5 (2.44%)	3.90%	17 (3.26%)	4.99%
ABOUT ONCE A MONTH	26 (2.99%)	8.17%	0	3.16%	7 (3.41%)	7.31%	30 (5.76%)	10.75%
LESS THAN ONCE A MONTH	45 (5.18%)	13.35%	3 (3.16%)	6.32%	11 (5.37%)	12.68%	58 (11.13%)	21.88%
DO NOT USE	753(86.65%)		89 (93.68%)		179(87.32%)		407(78.11%)	
TOTAL	869		95		205		521	
NO ANSWER	167(16.12%)		5 (5%)		17(7.66%)		27 (4.93%)	
RESPONSE RATE	83.88%		95%		92.34%		95.07%	

*"Downer" refers to barbiturates, tranquilizers, hypnotic-sedatives (Methaqualone is considered a "downer".

QUESTION: "HOW OFTEN DO YOU NOW USE EACH OF THE FOLLOWING?"
THIS TABLE REPRESENTS PERSONAL "UPPER"* USE

	ARMY	Cumulative	AIR FORCE	Cumulative	MARINES	Cumulative	NAVY	Cumulative
DAILY	14 (1.60%)	1.60%	1 (1.05%)	1.05%	1 (0.48%)	0.48%	10(1.90%)	1.90%
SEVERAL TIMES PER WEEK	30 (3.42%)	5.02%	2 (2.11%)	3.16%	7 (3.38%)	3.86%	39 (7.41%)	9.31%
ABOUT ONCE A WEEK	28 (3.20%)	8.22%	1 (1.05%)	4.21%	11(5.31%)	9.17%	43 (8.17%)	17.48%
ABOUT ONCE A MONTH	35 (3.99%)	12.21%	1 (1.05%)	5.26%	12(5.80%)	14.97%	48 (9.13%)	26.61%
LESS THAN ONCE A MONTH	67 (7.65%)	19.86%	4 (4.21%)	9.47%	19 (9.18%)	24.15%	56 (10.65%)	37.26%
DO NOT USE	702 (80.14%)		86 (90.53%)		157(75.85%)		330(62.74%)	
TOTAL	876		95		207		526	
NO ANSWER	160(15.44%)		5 (5%)		15 (6.76%)		22 (4.01%)	
RESPONSE RATE	84.56%		95%		93.24%		95.99%	

---

* "Upper" generally refers to drugs which are central nervous system stimulants and classically include the amphetamine and methamphetamine products as well as other stimulants. The class upper does not generally include cocaine although cocaine is a substance which is a central nervous system stimulant.

QUESTION: "HOW OFTEN DO YOU NOW USE EACH OF THE FOLLOWING?"
THIS TABLE REPRESENTS PERSONAL PCP USE

	ARMY	Cumulative	AIR FORCE	Cumulative	MARINES	Cumulative	NAVY	Cumulative
DAILY	5 (0.58%)	0.58%	1 (1.06%)	1.06%	0	0%	0	0%
SEVERAL TIMES PER WEEK	1 (0.12%)	0.7%	0	1.06%	0	0%	1 (0.2%)	0.2%
ABOUT ONCE A WEEK	1 (0.12%)	0.82%	0	1.06%	1 (0.5%)	0.5%	1 (0.2%)	0.4%
ABOUT ONCE A MONTH	9 (1.05%)	1.87%	0	1.06%	1 (0.5%)	1.0%	9 (1.75%)	2.15%
LESS THAN ONCE A MONTH	15 (1.75%)	3.62%	1 (1.06%)	2.12%	7 (3.5%)	4.5%	22 (4.3%)	6.45%
DO NOT USE	827 (96.38%)		92 (97.87%)		191 (95.5%)		479 (93.55%)	
TOTAL	858		94		200		512	
NO ANSWER	178 (17.18%)		6 (6%)		22 (9.91%)		36 (6.57%)	
RESPONSE RATE	82.82%		94%		90.09%		93.43%	

QUESTION: "HOW OFTEN DO YOU NOW USE EACH OF THE FOLLOWING?"
THIS TABLE REPRESENTS PERSONAL "OTHER DRUG" E.G. LSD, PEYOTE, ETC USE

	ARMY	Cumulative	AIR FORCE	Cumulative	MARINES	Cumulative	NAVY	Cumulative
DAILY	7 (0.82%)	0.82%	1 (1.09%)	1.09%	1 (0.5%)	0.5%	1 (0.2%)	0.2%
SEVERAL TIMES PER WEEK	4 (0.47%)	1.29%	0	1.09%	2 (1.0%)	1.50%	2 (0.39%)	0.59%
ABOUT ONCE A WEEK	5 (0.59%)	1.88%	0	1.09%	3 (1.50%)	3.0%	9 (1.77%)	2.36%
ABOUT ONCE A MONTH	18 (2.11%)	3.99%	1 (1.09%)	2.18%	5 (2.5%)	5.5%	30 (5.89%)	8.25%
LESS THAN ONCE A MONTH	51 (5.98%)	9.97%	1 (1.09%)	3.27%	12 (6%)	11.5%	44 (8.64%)	16.9%
DO NOT USE	768 (90.03%)		89 (96.73%)		177(88.5%)		423 (83.1%)	
TOTAL	853		92		200		509	
NO ANSWER	183 (17.66%)		8 (8%)		22 (9.91%)		39 (7.12%)	
RESPONSE RATE	82.34%		92%		90.09%		92.88%	

QUESTION: "HOW OFTEN DO YOU NOW USE EACH OF THE FOLLOWING?"
THIS TABLE REPRESENTS PERSONAL ALCOHOL USE

	ARMY		AIR FORCE		MARINES		NAVY	
		Cumulative		Cumulative		Cumulative		Cumulative
DAILY	227 (24%)	24%	13 (13.27%)	13.27%	21 (9.81%)	9.81%	57 (10.69%)	10.69%
SEVERAL TIMES PER WEEK	232 (24.52%)	48.52%	20 (20.41%)	33.68%	71 (33.18%)	42.99%	163(30.58%)	41.27%
ABOUT ONCE A WEEK	178 (18.82%)	67.34%	28 (28.57%)	62.25%	48 (22.43%)	65.42%	131(24.58%)	65.85%
ABOUT ONCE A MONTH	50 (5.29%)	72.63%	10 (10.2%)	72.45%	25 (11.68%)	77.1%	57 (10.69%)	76.54%
LESS THAN ONCE A MONTH	49 (5.18%)	77.8%	8 (8.16%)	80.61%	11 (5.14%)	82.24%	44 (8.26%)	84.8%
DO NOT USE	210 (22.2%)		19 (19.39%)		38 (17.76%)		81 (15.2%)	
TOTAL	946		98		214		533	
NO ANSWER	90(8.69%)		2 (2%)		8 (3.6%)		15 (2.74%)	
RESPONSE RATE	91.31%		98%		96.4%		97.26%	

DRUG USE ON DUTY

SUMMARY OF DATA

QUESTION: "DURING THE LAST MONTH, HAVE YOU USED ANY OF THE FOLLOWING WHILE ON DUTY (DURING WORKING HOURS)?"

(Percentages indicate affirmative answers)

	ARMY	AIR FORCE	MARINES	NAVY
MARIHUANA/HASHISH	38%	4.5%	24.34%	41.86%
COCAINE	3.03%	0	3.9%	3.82%
HEROIN	1.99%	0	0.55%	0.57%
UPPERS	9.6%	0	13.7%	27.05%
DOWNERS	4.56%	0	4.9%	10.13%
PCP	0.47%	0	0	0.19%
OTHER DRUGS (LSD, PEYOTE,ETC)	2.11%	0	2.2%	8.65%
ALCOHOL	28.01%	15.7%	19.4%	20.95%

USE OF DRUGS ON DUTY

USE OF ANY DRUG AND/OR ALCOHOL
ON DUTY (DURING WORKING HOURS)
IN THE LAST MONTH*

42.29% OF THE TOTAL SUBJECT POPULATION (1906 RESPONDENTS) ADMITTED USING DRUGS/ALCOHOL DURING THE MONTH PRECEDING THE ADMINISTERING OF THE SELECT COMMITTEE'S SURVEY.

ARMY.............42.66% ADMITTED ON DUTY USE
AIR FORCE........17.00% ADMITTED ON DUTY USE
MARINES..........34.68% ADMITTED ON DUTY USE
NAVY.............49.27% ADMITTED ON DUTY USE

U.S.S. FORRESTAL

60.224% OF THE NAVY E-1 TO E-4 POPULATION SURVEYED ABOARD THE U.S.S. FORRESTAL ADMITTED USING DRUGS/ALCOHOL AT LEAST ONCE DURING THE MONTH PRECEDING THE ADMINISTERING OF THE SELECT COMMITTEE'S SURVEY

ON DUTY USAGE ABOARD THE FORRESTAL

52.4%......MARIHUANA/HASHISH ON DUTY
5.3%......COCAINE ON DUTY
36.13%......UPPERS ON DUTY
14.2%......DOWNERS ON DUTY
12.0%......OTHER DRUGS (LSD, PEYOTE, ETC.) ON DUTY
23.0%......ALCOHOL ON DUTY

---

*IN THE LAST MONTH PRECEDING ADMINISTERING OF THE SELECT COMMITTEE'S SURVEY QUESTIONNAIRE.

QUESTION: "DURING THE LAST MONTH HAVE YOU USED ANY OF THE FOLLOWING WHILE ON DUTY (DURING WORKING HOURS)?"

DRUG MARIHUANA/HASHISH

	ARMY	AIR FORCE	MARINES	NAVY
YES	345 (38%)	4 (4.5%)	46 (24.34%)	221 (41.86%)
NO	563 (62%)	84 (95.5%)	143 (75.66%)	307 (58.14%)
TOTAL	908	88	189	528
NO ANSWER	128 (12.36%)	12 (12%)	33 (14.86%)	20 (3.65%)
RESPONSE RATE	87.64%	88%	85.14%	96.35%

QUESTION: "DURING THE LAST MONTH HAVE YOU USED ANY OF THE FOLLOWING WHILE ON DUTY (DURING WORKING HOURS)?"

DRUG COCAINE

	ARMY	AIR FORCE	MARINES	NAVY
YES	26 (3.03%)	0	7 (3.9%)	20 (3.82%)
NO	831 (96.97%)	87 (100%)	174 (96.1%)	503 (96.18%)
TOTAL	857	87	181	523
NO ANSWER	179 (17.28%)	13 (13%)	41 (18.5%)	25 (4.56%)
RESPONSE RATE	82.72%	87%	81.5%	95.44%

QUESTION: "DURING THE LAST MONTH HAVE YOU USED ANY OF THE FOLLOWING WHILE ON DUTY (DURING WORKING HOURS)?"

DRUG HEROIN

	ARMY	AIR FORCE	MARINES	NAVY
YES	17 (1.99%)	0	1 (0.55%)	3 (0.57%)
NO	839 (98.01%)	87 (100%)	180 (99.45%)	519 (99.43%)
TOTAL	856	87	181	522
NO ANSWER	180 (17.37%)	13 (13%)	41 (18.5%)	26 (4.74%)
RESPONSE RATE	82.63%	87%	81.5%	95.26%

QUESTION: "DURING THE LAST MONTH HAVE YOU USED ANY OF THE FOLLOWING WHILE ON DUTY (DURING WORKING HOURS)?"

DRUG "DOWNERS"

	ARMY	AIR FORCE	MARINES	NAVY
YES	39 (4.56%)	0	9 (4.9%)	53 (10.13%)
NO	817 (95.44%)	87 (100%)	173 (95.1%)	470 (89.87%)
TOTAL	856	87	182	523
NO ANSWER	180 (17.37%)	13 (13%)	40 (18%)	25 (4.56%)
RESPONSE RATE	82.63%	87%	82%	95.44%

QUESTION: "DURING THE LAST MONTH HAVE YOU USED ANY OF THE FOLLOWING WHILE ON DUTY (DURING WORKING HOURS)?"

DRUG "UPPERS" (E.G. AMPHETAMINES, ETC.)

	ARMY	AIR FORCE	MARINES	NAVY
YES	82 (9.6%)	0	25 (13.7%)	142 (27.05%)
NO	773 (90.4%)	87 (100%)	157 (86.3%)	383 (72.95%)
TOTAL	855	87	182	525
NO ANSWER	181 (17.47%)	13 (13%)	40 (18%)	23 (4.20%)
RESPONSE RATE	82.53%	87%	82%	95.8%

QUESTION: "DURING THE LAST MONTH HAVE YOU USED ANY OF THE FOLLOWING WHILE ON DUTY (DURING WORKING HOURS)?"

DRUG PCP

	ARMY	AIR FORCE	MARINES	NAVY
YES	4 (0.47%)	0	0	1 (0.19%)
NO	851 (99.53%)	87 (100%)	180 (100%)	520 (99.81%)
TOTAL	855	87	180	521
NO ANSWER	181 (17.47%)	13 (13%)	42 (18.9%)	27 (4.93%)
RESPONSE RATE	82.53%	87%	81.1%	95.07%

QUESTION: "DURING THE LAST MONTH HAVE YOU USED ANY OF THE FOLLOWING WHILE ON DUTY (DURING WORKING HOURS)?"

DRUG OTHER (LSD, PEYOTE, ETC.)

	ARMY	AIR FORCE	MARINES	NAVY
YES	18 (2.11%)	0	4 (2.2%)	45 (8.65%)
NO	834 (97.89%)	87 (100%)	176 (97.8%)	475 (91.35%)
TOTAL	852	87	180	520
NO ANSWER	184 (17.76%)	13 (13%)	42 (18.9%)	28 (5.11%)
RESPONSE RATE	82.24%	87	81.1%	94.89%

QUESTION: "DURING THE LAST MONTH HAVE YOU USED ANY OF THE FOLLOWING WHILE ON DUTY (DURING WORKING HOURS)?"

DRUG ALCOHOL

	ARMY	AIR FORCE	MARINES	NAVY
YES	244 (28.01%)	14 (15.7%)	36 (19.4%)	110 (20.95%)
NO	627 (71.99%)	75 (84.3%)	150 (80.6%)	415 (79.05%)
TOTAL	871	89	186	525
NO ANSWER	165 (15.93%)	11 (11%)	36 (16.2%)	23 (4.20%)
RESPONSE RATE	84.07%	89%	83.8%	95.8%

DRUG AND ALCOHOL TREATMENT PROGRAMS

QUESTION:"ARE YOU NOW IN YOUR SERVICE'S DRUG/ALCOHOL TREATMENT PROGRAM?

	ARMY	AIR FORCE	MARINES	NAVY
YES	38 (4.4%)	1 (1.14%)	2 (1.09%)	8 (1.6%)
NO	826 (95.6%)	87 (98.86%)	182 (98.91%)	496 (98.4%)
TOTAL	864	88	184	504
NO RESPONSE	172 (16.6%)	12 (12%)	38 (17.12%)	44 (8.03%)
RESPONSE RATE	83.4%	88%	82.88%	91.97%

QUESTION: "HAVE YOU EVER BEEN IN YOUR SERVICE'S DRUG/ALCOHOL TREATMENT PROGRAM?"

	ARMY	AIR FORCE	MARINES	NAVY
YES	86 (9.98%	5 (5.7%)	16 (8.7%)	49 (9.72%)
NO	776 (90.02%	83 (94.3%)	168 (91.3%)	455 (90.28%)
TOTAL	862	88	184	504
NO RESPONSE	174 (16.8%)	12 (12%)	38 (17.12%)	44 (8.03%)
RESPONSE RATE	83.2%	88%	82.88	91.97%

QUESTION: "HOW WOULD YOU RATE YOUR SERVICE'S DRUG ABUSE TREATMENT PROGRAM?"

	ARMY	AIR FORCE	MARINE	NAVY
EXCELLENT	44 (5.54%)	2 (2.60%)	19 (11.3%)	17 (3.80%)
GOOD	131 (16.5%)	25 (32.5%)	43 (25.6%)	105 (23.2%)
FAIR	280 (35.26%)	23 (29.9%)	58 (34.5%)	173 (38.2%)
POOR	339 (42.7%)	27 (35%)	48 (28.6%)	158 (34.8%)
TOTAL	794	77	168	453
NO ANSWER	242 (23.36%)	23 (23%)	54 (24.32%)	95 (17.34%)
RESPONSE RATE	76.64%	77%	75.68%	82.66%

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS IN ARMY DRUG/ALCOHOL TREATMENT PROGRAMS AT TIME OF SURVEY

DRUG MARIHUANA/HASHISH

		CUMULATIVE
DAILY	7 (21.21%)	21.21%
SEVERAL TIMES PER WEEK	9 (27.27%)	48.48%
ABOUT ONCE PER WEEK	2 (6.06%)	54.54%
ABOUT ONCE PER MONTH	5 (15.15%)	69.69%
LESS THAN ONCE PER MONTH	2 (6.06%)	75.75%
DO NOT USE	8 (24.24%)	
TOTAL	33	
NO RESPONSE	5 (13.16%)	
RESPONSE RATE	86.84%	

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED.

DRUG MARIHUANA/HASHISH

	ARMY		NAVY	
		(CUMULATIVE)		(CUMULATIVE)
DAILY	24 (30%)	30%	19 (39.58%)	39.58%
SEVERAL TIMES PER WEEK	19 (23.75%)	53.75%	8 (16.67%)	56.25%
ABOUT ONCE PER WEEK	10 (12.5%)	66.25%	4 (8.33%)	64.58%
ABOUT ONCE PER MONTH	3 (3.75%)	70%	4 (8.33%)	72.91%
LESS THAN ONCE PER MONTH	5 (6.25%)	76.25%	2 (4.17%)	77.08%
DO NOT USE	19 (23.75%		11 (22.92%)	
TOTAL	80		48	
NO RESPONSE	6 (6.98%)		1 (2.04%)	
RESPONSE RATE	93.02%		97.96%	

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS IN ARMY DRUG/ ALCOHOL TREATMENT PROGRAMS AT TIME OF SURVEY

DRUG COCAINE

		CUMULATIVE
DAILY	0	0
SEVERAL TIMES PER WEEK	0	0
ABOUT ONCE PER WEEK	0	0
ABOUT ONCE PER MONTH	2 (7.69%)	7.69%
LESS THAN ONCE PER MONTH	2 (7.69%)	15.38%
DO NOT USE	22 (84.62%)	
TOTAL	26	
NO RESPONSE	12 (31.58%)	
RESPONSE RATE	68.42%	

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED.

DRUG COCAINE

	ARMY		NAVY	
		(CUMULATIVE)		(CUMULATIVE)
DAILY	0	0	0	0
SEVERAL TIMES PER WEEK	0	0	1 (2.22%)	2.22%
ABOUT ONCE PER WEEK	1 (1.45%)	1.45%	0	2.22%
ABOUT ONCE PER MONTH	5 (7.25%)	8.7%	11 (24.44%)	26.66%
LESS THAN ONCE PER MONTH	10(14.49%)	23.19%	10 (22.22%)	48.88%
DO NOT USE	53 (76.81%		23(51.11%)	
TOTAL	69		45	
NO RESPONSE	17 (19.77%)		4 (8.16%)	
RESPONSE RATE	80.23%		91.84%	

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS IN ARMY DRUG/ ALCOHOL TREATMENT PROGRAMS AT TIME OF SURVEY

DRUG HEROIN

		CUMULATIVE
DAILY	0	0
SEVERAL TIMES PER WEEK	1 (3.85%)	3.85%
ABOUT ONCE PER WEEK	0	3.85%
ABOUT ONCE PER MONTH	0	3.85%
LESS THAN ONCE PER MONTH	0	3.85%
DO NOT USE	25 (96.15%)	
TOTAL	26	
NO RESPONSE	12 (31.85%)	
RESPONSE RATE	68.42%	

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED.

DRUG HEROIN

	ARMY	(CUMULATIVE)	NAVY	(CUMULATIVE)
DAILY	0	0	0	0
SEVERAL TIMES PER WEEK	2 (2.86%)	2.86%	0	0
ABOUT ONCE PER WEEK	0	2.86%	0	0
ABOUT ONCE PER MONTH	2 (2.86%)	5.72%	0	0
LESS THAN ONCE PER MONTH	3 (4.28%)	10%	4 (8.89%)	8.89%
DO NOT USE	63 (90%)		41 (91.11%)	
TOTAL	70		45	
NO RESPONSE	16 (18.6%)		4 (8.16%)	
RESPONSE RATE	81.4%		91.84%	

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS IN ARMY DRUG/ALCOHOL TREATMENT PROGRAMS AT TIME OF SURVEY

DRUG DOWNERS

		CUMULATIVE
DAILY	0	0
SEVERAL TIMES PER WEEK	3 (11.54%)	11.54%
ABOUT ONCE PER WEEK	1 (3.85%)	15.39%
ABOUT ONCE PER MONTH	0	15.39%
LESS THAN ONCE PER MONTH	3 (11.54%)	26.93%
DO NOT USE	19 (73.07%)	
TOTAL	26	
NO RESPONSE	12 (31.85%)	
RESPONSE RATE	68.42%	

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED.

DRUG "DOWNERS"

	ARMY		NAVY	
		(CUMULATIVE)		(CUMULATIVE)
DAILY	1 (1.45%)	1.45%	0	0
SEVERAL TIMES PER WEEK	1 (1.45%)	2.9%	1 (2.22%)	2.22%
ABOUT ONCE PER WEEK	3 (4.35%)	7.25%	4 (8.89%)	11.11%
ABOUT ONCE PER MONTH	5 (7.25%)	14.5%	9 (20%)	31.11%
LESS THAN ONCE PER MONTH	8 (11.59%)	26.09%	9 (20%)	51.11%
DO NOT USE	51 (73.91%)		22(48.89%)	
TOTAL	69		45	
NO RESPONSE	17 (19.77%		4 (8.16%)	
RESPONSE RATE	80.23%		91.84%	

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS IN ARMY DRUG/ ALCOHOL TREATMENT PROGRAMS AT TIME OF SURVEY

DRUG UPPERS

		CUMULATIVE
DAILY	0	0
SEVERAL TIMES PER WEEK	2 (7.14%)	7.14%
ABOUT ONCE PER WEEK	2 (7.14%)	14.28%
ABOUT ONCE PER MONTH	0	14.28%
LESS THAN ONCE PER MONTH	6 (21.43%)	35.71%
DO NOT USE	18(64.29%)	
TOTAL	28	
NO RESPONSE	10 (26.32%)	
RESPONSE RATE	73.68	

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED.

DRUG "UPPERS"

	ARMY		NAVY	
		(CUMULATIVE)		(CUMULATIVE)
DAILY	2 (2.74%)	2.74%	1 (2.22%)	2.22%
SEVERAL TIMES PER WEEK	4 (5.48%)	8.22%	12 (26.67%)	28.89%
ABOUT ONCE PER WEEK	5 (6.85%)	15.07%	7 (15.55%)	44.44%
ABOUT ONCE PER MONTH	8 (10.96%)	26.03%	4 (8.89%)	53.33%
LESS THAN ONCE PER MONTH	11(15.07%)	41.10%	7 (15.55%)	68.88%
DO NOT USE	43 (58.9%)		14 (31.11%)	
TOTAL	73		45	
NO RESPONSE	13(15.12%)		4 (8.16%)	
RESPONSE RATE	84.88		91.84%	

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS IN ARMY DRUG/ALCOHOL TREATMENT PROGRAMS AT TIME OF SURVEY

DRUG PCP

		CUMULATIVE
DAILY	0	0
SEVERAL TIMES PER WEEK	1(4%)	4%
ABOUT ONCE PER WEEK	0	4%
ABOUT ONCE PER MONTH	1 (4%)	8%
LESS THAN ONCE PER MONTH	0	8%
DO NOT USE	23 (92%)	
TOTAL	25	
NO RESPONSE	13 (34.21%)	
RESPONSE RATE	65.79%	

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED.

DRUG PCP

	ARMY		NAVY	
		(CUMULATIVE)		(CUMULATIVE)
DAILY	0	0	0	0
SEVERAL TIMES PER WEEK	0	0	1 (2.27%)	2.27%
ABOUT ONCE PER WEEK	0	0	0	2.27%
ABOUT ONCE PER MONTH	2 (3.03%)	3.03%	5 (11.36%)	13.63%
LESS THAN ONCE PER MONTH	2 (3.03%)	6.06%	5 (11.36%)	24.99%
DO NOT USE	62 (93.94%		33 (75%)	
TOTAL	66		44	
NO RESPONSE	20 (23.26%		5 (10.2%)	
RESPONSE RATE	76.24%		89.8%	

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS IN ARMY DRUG/ ALCOHOL TREATMENT PROGRAMS AT TIME OF SURVEY

DRUG OTHER DRUGS (LSD, PEYOTE, ETC)

		CUMULATIVE
DAILY	0	0
SEVERAL TIMES PER WEEK	1 (3.7%)	3.7%
ABOUT ONCE PER WEEK	1 (3.7%)	7.4%
ABOUT ONCE PER MONTH	1 (3.7%)	11.1%
LESS THAN ONCE PER MONTH	2 (7.4%)	18.5%
DO NOT USE	22 (81.5%)	
TOTAL	27	
NO RESPONSE	11 (28.95%)	
RESPONSE RATE	71.05%	

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED.

DRUG OTHER (LSD, PEYOTE, ETC)

	ARMY		NAVY	
		(CUMULATIVE)		(CUMULATIVE)
DAILY	0	0	0	0
SEVERAL TIMES PER WEEK	1 (1.51%)	1.51%	0	0
ABOUT ONCE PER WEEK	1 (1.51%)	3.02%	6 (14.285%)	14.285%
ABOUT ONCE PER MONTH	5 (7.58%)	10.6%	7 (16.666%)	30.951%
LESS THAN ONCE PER MONTH	5 (7.58%)	18.18%	5 (11.9%)	42.851%
DO NOT USE	54(81.82%)		24 (57.14%)	
TOTAL	66		42	
NO RESPONSE	20(23.26%)		7 (14.29%)	
RESPONSE RATE	76.74%		85.71%	

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS IN ARMY DRUG/ ALCOHOL TREATMENT PROGRAMS AT TIME OF SURVEY

DRUG ALCOHOL

		CUMULATIVE
DAILY	10 (33.33%)	33.33%
SEVERAL TIMES PER WEEK	8 (26.67%)	60%
ABOUT ONCE PER WEEK	4 (13.33%)	73.33%
ABOUT ONCE PER MONTH	1 (3.33%)	76.66%
LESS THAN ONCE PER MONTH	0	76.66%
DO NOT USE	7 (23.33)	
TOTAL	30	
NO RESPONSE	8 (21.05%)	
RESPONSE RATE	78.95%	

CURRENT USE OF DRUGS AND ALCOHOL BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED.

DRUG ALCOHOL

	ARMY		NAVY	
		(CUMULATIVE)		(CUMULATIVE)
DAILY	35 (43.75%)	43.75%	9(19.15%)	19.15%
SEVERAL TIMES PER WEEK	19 (23.75%)	67.5%	14 (29.79%)	48.94%
ABOUT ONCE PER WEEK	11 (13.75%)	81.25%	12 (25.53%)	74.47%
ABOUT ONCE PER MONTH	3 (3.75%)	85%	6 (12.76%)	87.23%
LESS THAN ONCE PER MONTH	1 (1.25%)	86.25%	0	87.23%
DO NOT USE	11(13.75%)		6 (12.76%)	
TOTAL	80		47	
NO RESPONSE	6 (6.98%)		2 (4.08%	
RESPONSE RATE	93.02%		95.92%	

USE OF DRUGS AND ALCOHOL ON DUTY (DURING WORKING HOURS) BY SUBJECTS IN ARMY DRUG/ALCOHOL TREATMENT PROGRAMS AT TIME OF SURVEY.

	MARIHUANA/ HASHISH	COCAINE	HEROIN	DOWNERS	UPPERS	PCP	OTHERS	ALCOHOL
YES	20 (55.55%)	2 (6.06%)	1 (3.03%)	2 (6.06%)	6 (18.18%)	0	0	13 (38.24%)
NO	16 (44.44%	31 (93.94%)	32 (96.97%)	31 (93.94%)	27(81.82%)	33(100%)	33(100%)	21 (61.76%)
TOTAL	36	33	33	33	33	33	33	34
NO RESPONSE	2 (5.26%)	5 (13.16%)	5 (13.16%)	5 (13.16%)	5 (13.16%)	5(13.16%)	5(13.16%)	4 (10.53%)
RESPONSE RATE	94.74	86.84%	86.84%	86.84%	86.84%	86.84%	86.84%	89.47%

USE OF DRUGS ON DUTY IN MONTH PRECEDING SURVEY

USE OF DRUGS AND ALCOHOL ON DUTY (DURING WORKING HOURS) BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED

DRUG MARIHUANA/HASHISH

	ARMY	NAVY
YES	51 (61.45%)	29 (59.18%)
NO	32 (38.55%)	20 (40.82%)
TOTAL	83	49
NO RESPONSE	3 (3.49%)	0
RESPONSE RATE	96.51%	100%

USE OF DRUGS ON DUTY IN MONTH PRECEDING SURVEY

USE OF DRUGS AND ALCOHOL ON DUTY (DURING WORKING HOURS) BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED

DRUG COCAINE

	ARMY	NAVY
YES	4 (5.06%)	6 (12.5%)
NO	75 (94.94%)	42 (87.5%)
TOTAL	79	48
NO RESPONSE	7 (8.14%)	1 (2.04%)
RESPONSE RATE	91.86%	97.96%

USE OF DRUGS ON DUTY IN MONTH PRECEDING SURVEY

USE OF DRUGS AND ALCOHOL ON DUTY (DURING WORKING HOURS) BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED

DRUG HEROIN

	ARMY	NAVY
YES	3 (3.8%)	1 (2.08%)
NO	76 (96.2%)	47 (97.92%)
TOTAL	79	48
NO RESPONSE	7 (8.14%)	1 (2.04%)
RESPONSE RATE	91.86%	97.96%

USE OF DRUGS ON DUTY IN MONTH PRECEDING SURVEY

USE OF DRUGS AND ALCOHOL ON DUTY (DURING WORKING HOURS) BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED

DRUG "UPPERS"

	ARMY	NAVY
YES	17 (21.52%)	24 (50%)
NO	62 (78.48%)	24 (50%)
TOTAL	79	48
NO RESPONSE	7 (8.14%)	1 (2.04%)
RESPONSE RATE	91.86%	97.96%

USE OF DRUGS ON DUTY IN MONTH PRECEDING SURVEY

USE OF DRUGS AND ALCOHOL ON DUTY (DURING WORKING HOURS) BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED

DRUG "DOWNERS"

	ARMY	NAVY
YES	5 (6.33%)	14 (29.17%)
NO	74 (93.67%)	34 (70.83%)
TOTAL	79	48
NO RESPONSE	7 (8.14%)	1 (2.04%)
RESPONSE RATE	91.86%	97.96%

USE OF DRUGS ON DUTY IN MONTH PRECEDING SURVEY

USE OF DRUGS AND ALCOHOL ON DUTY (DURING WORKING HOURS) BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED

DRUG PCP

	ARMY	NAVY
YES	1 (1.27%)	1 (2,08%)
NO	78 (98.73%)	47 (97.92%)
TOTAL	79	48
NO RESPONSE	7 (8.14%)	1 (2.04%)
RESPONSE RATE	91.86%	97.96%

USE OF DRUGS ON DUTY IN MONTH PRECEDING SURVEY

USE OF DRUGS AND ALCOHOL ON DUTY (DURING WORKING HOURS) BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED

DRUG OTHER (LSD, PEYOTE, ETC)

	ARMY	NAVY
YES	1 (1.27%)	13 (27.08%)
NO	78 (98.73%)	35 (72.92%)
TOTAL	79	48
NO RESPONSE	7 (8.14%)	1 (2.04%)
RESPONSE RATE	91.86%	97.96%

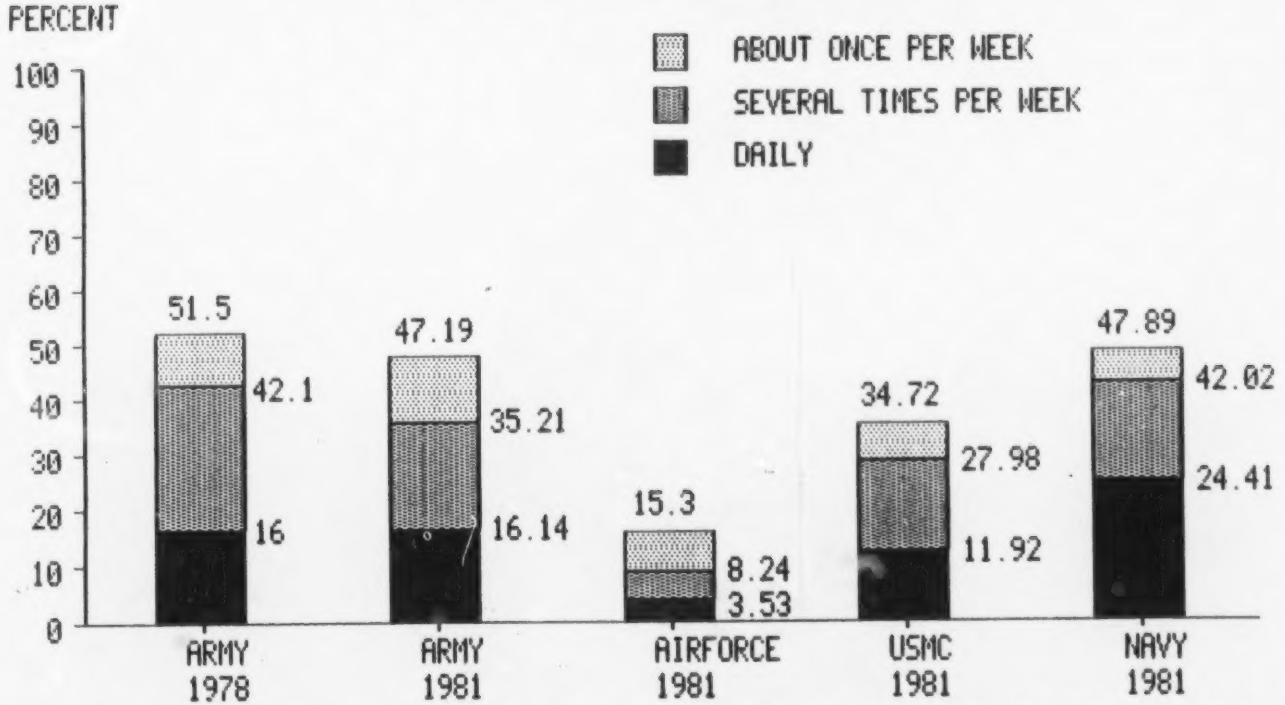
USE OF DRUGS ON DUTY IN MONTH PRECEDING SURVEY

USE OF DRUGS AND ALCOHOL ON DUTY (DURING WORKING HOURS) BY SUBJECTS RESPONDING THAT THEY HAD BEEN IN THE ARMY OR NAVY DRUG/ALCOHOL TREATMENT PROGRAM PRIOR TO THE TIME THAT THE SURVEY WAS CONDUCTED

DRUG ALCOHOL

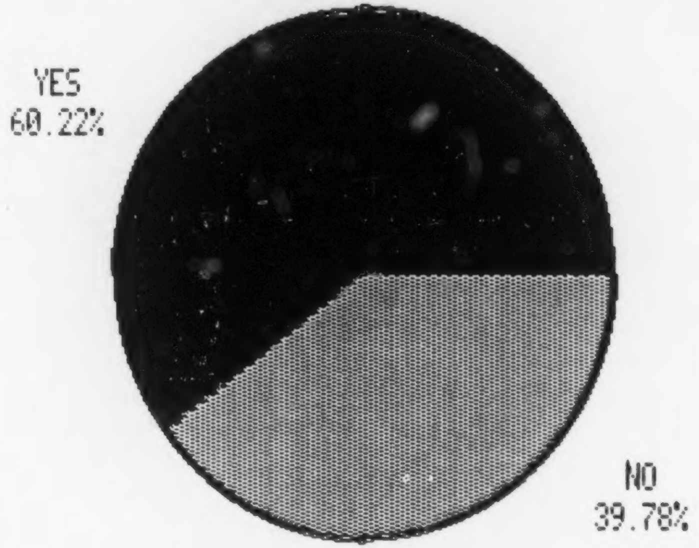
	ARMY	NAVY
YES	29 (36.25%)	14 (28.57%)
NO	51 (63.75%)	35 (71.43%)
TOTAL	80	49
NO RESPONSE	6 (6.98%)	0
RESPONSE RATE	93.02%	100%

RESPONDENTS (E1 - E4) ADMITTING TO WEEKLY OR MORE USE OF MARIHUANA/HASHISH



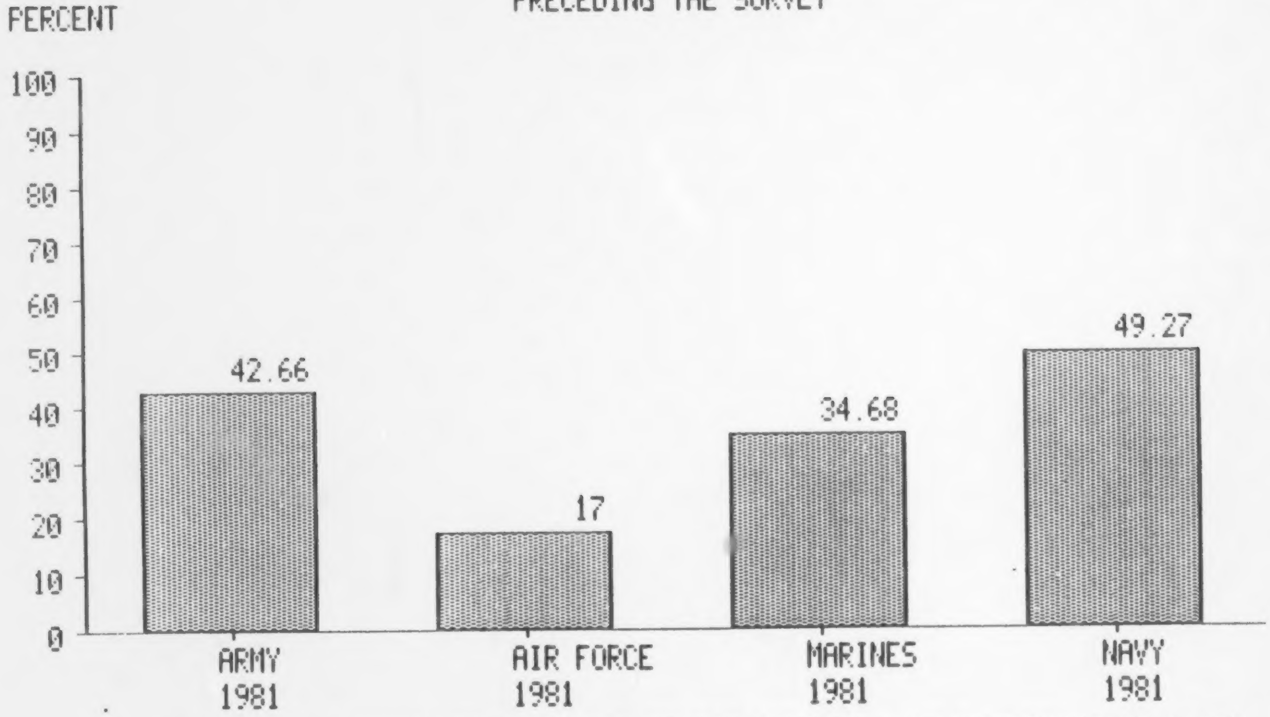
SOURCE: SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981).

USE OF ANY DRUG OR ALCOHOL ON DUTY BY NAVY E1 - E4
SURVEY POPULATION ABOARD U.S.S. FORRESTAL
IN THE MONTH PRECEDING THE SURVEY



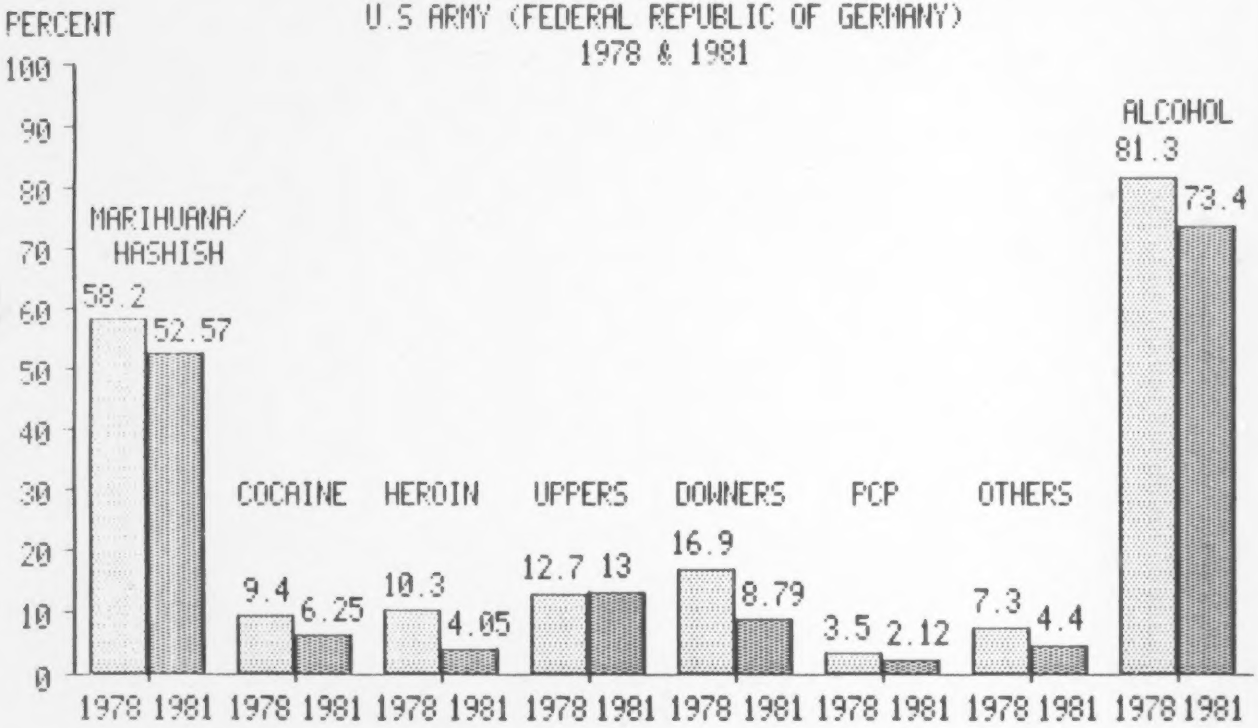
SOURCE: SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981).

USE OF ANY DRUG OR ALCOHOL ON DUTY
(DURING WORKING HOURS) IN THE MONTH
PRECEDING THE SURVEY



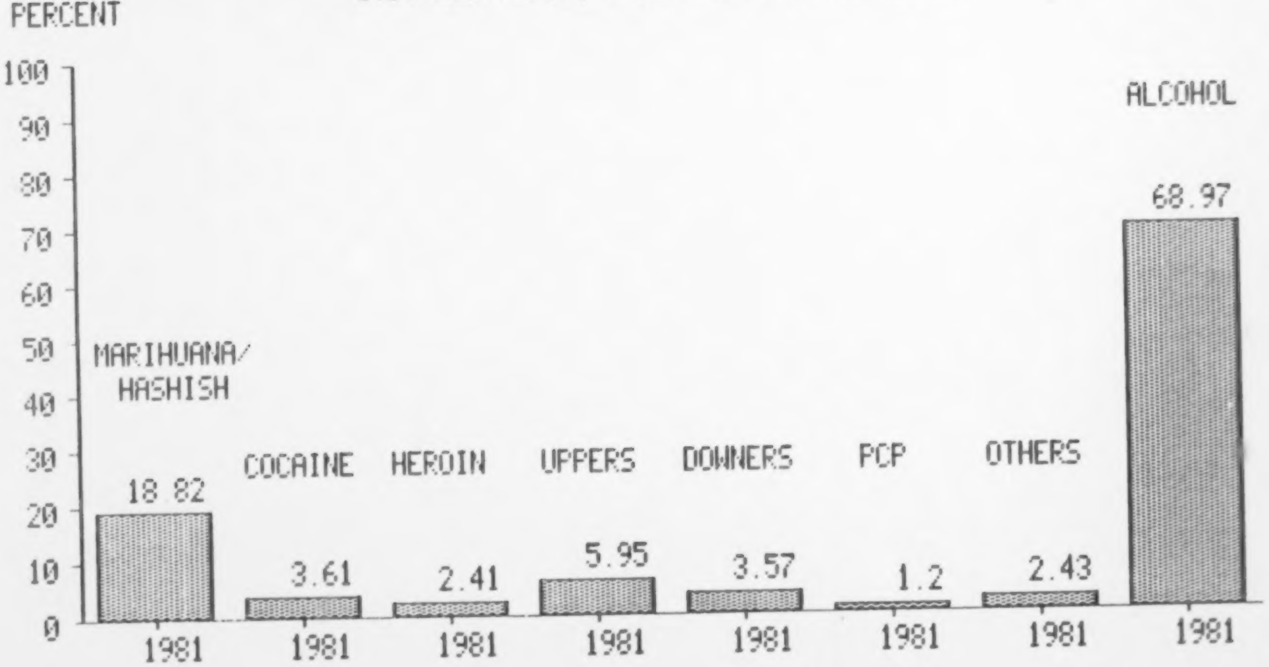
SOURCE SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981)

RESPONDENTS (E1 - E4) ADMITTING TO MONTHLY OR
MORE FREQUENT USE OF THE FOLLOWING DRUGS
U.S ARMY (FEDERAL REPUBLIC OF GERMANY)
1978 & 1981



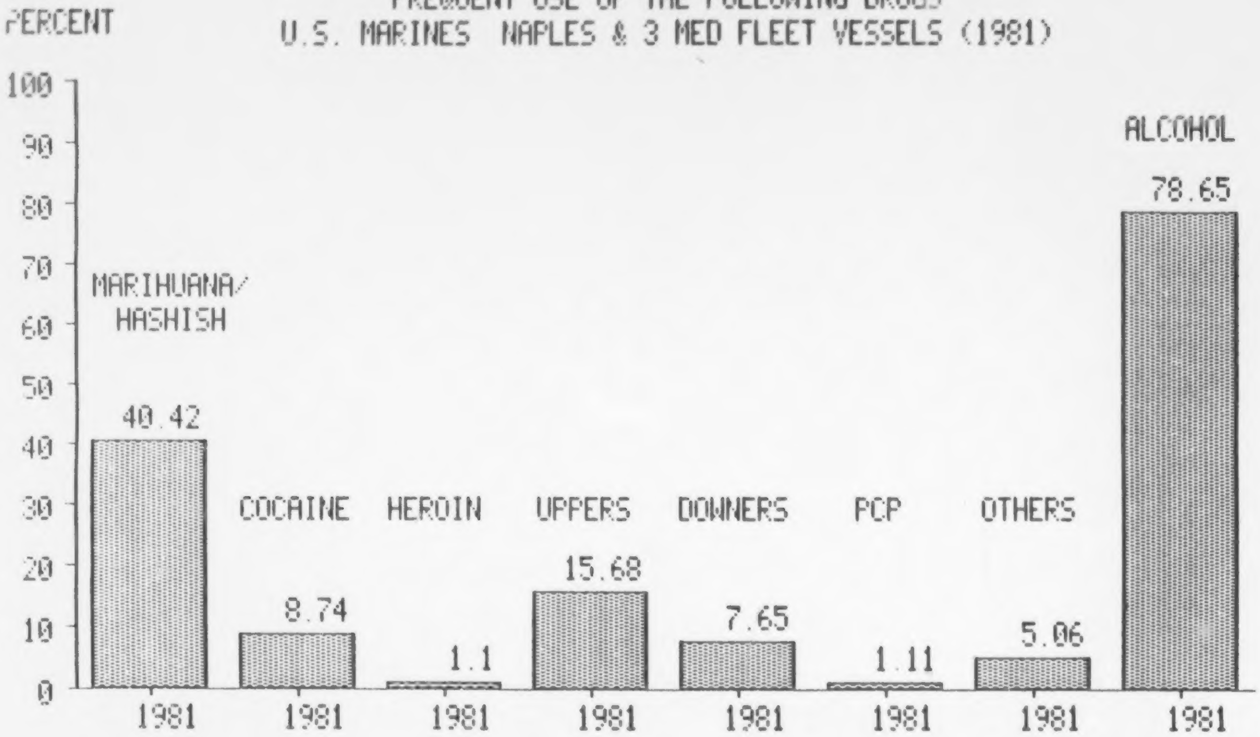
SOURCE. SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981)

RESPONDENTS (E1 - E4) ADMITTING TO MONTHLY OR MORE
FREQUENT USE OF THE FOLLOWING DRUGS
U.S. AIR FORCE, RAMSTEIN AB, FRG (1981)



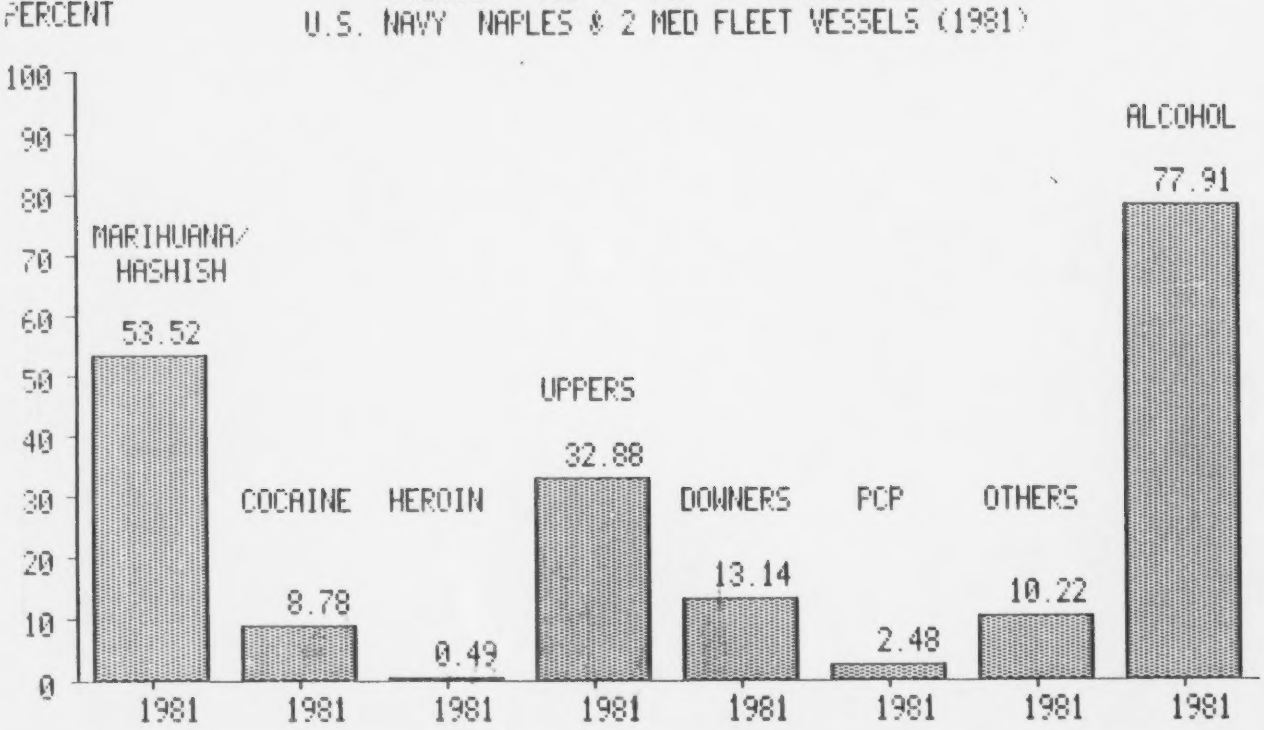
SOURCE: SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981)

RESPONDENTS (E1 - E4) ADMITTING TO MONTHLY OR MORE
FREQUENT USE OF THE FOLLOWING DRUGS
U.S. MARINES NAPLES & 3 MED FLEET VESSELS (1981)



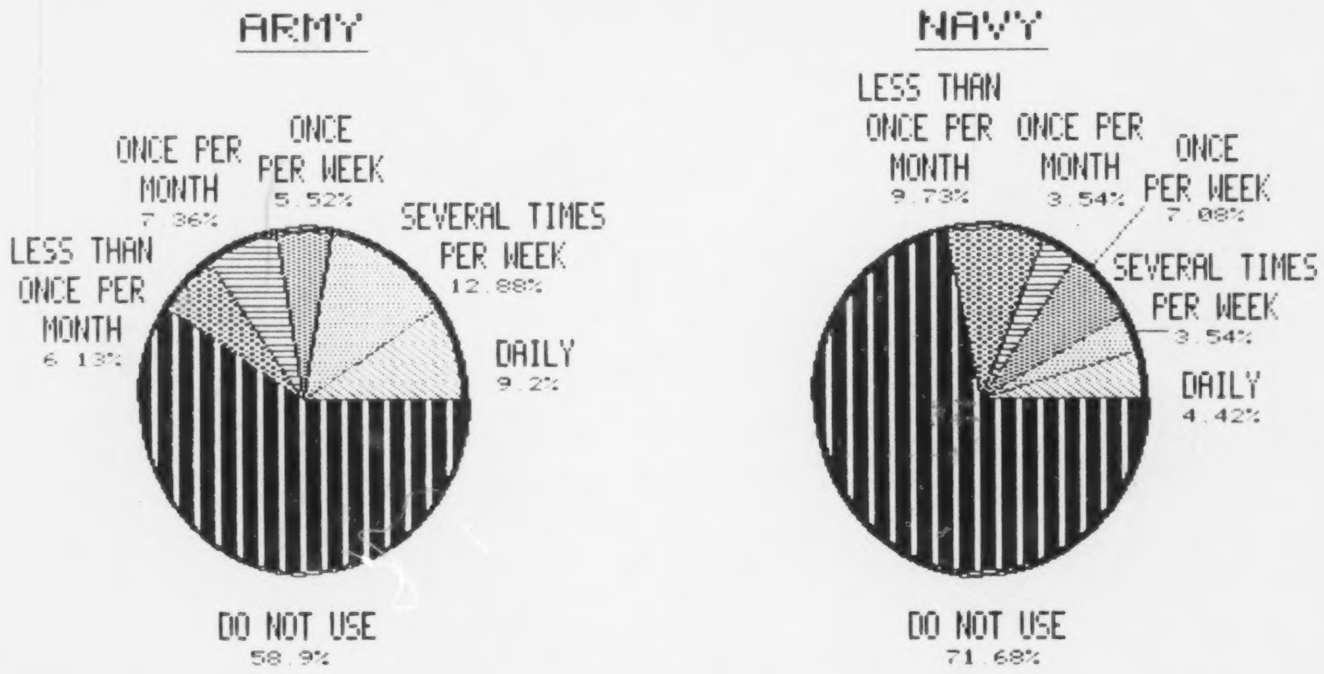
SOURCE SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981)

RESPONDENTS (E1 - E4) ADMITTING TO MONTHLY OR MORE FREQUENT USE OF THE FOLLOWING DRUGS
U.S. NAVY NAPLES & 2 MED FLEET VESSELS (1981)

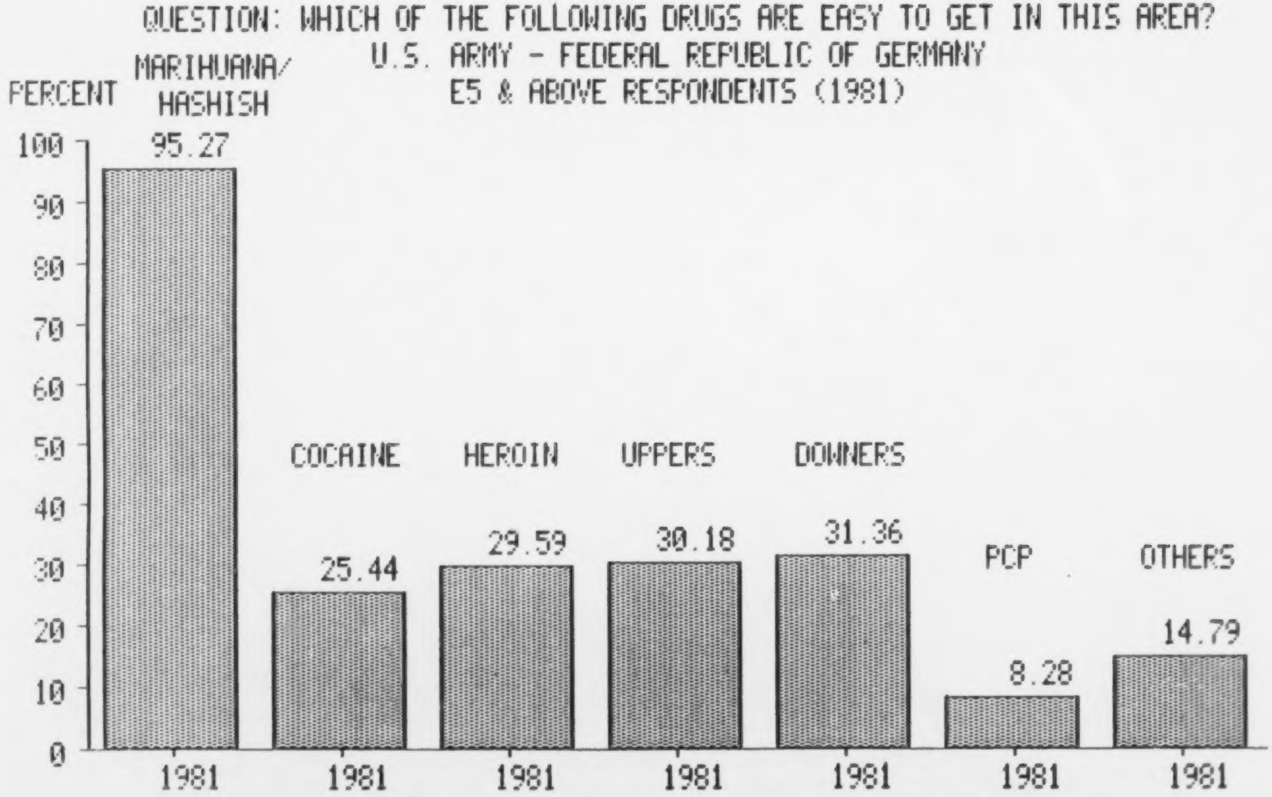


SOURCE. SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981)

CURRENT USE OF MARIHUANA/HASHISH BY NON-COMMISSIONED OFFICERS (ARMY & NAVY)



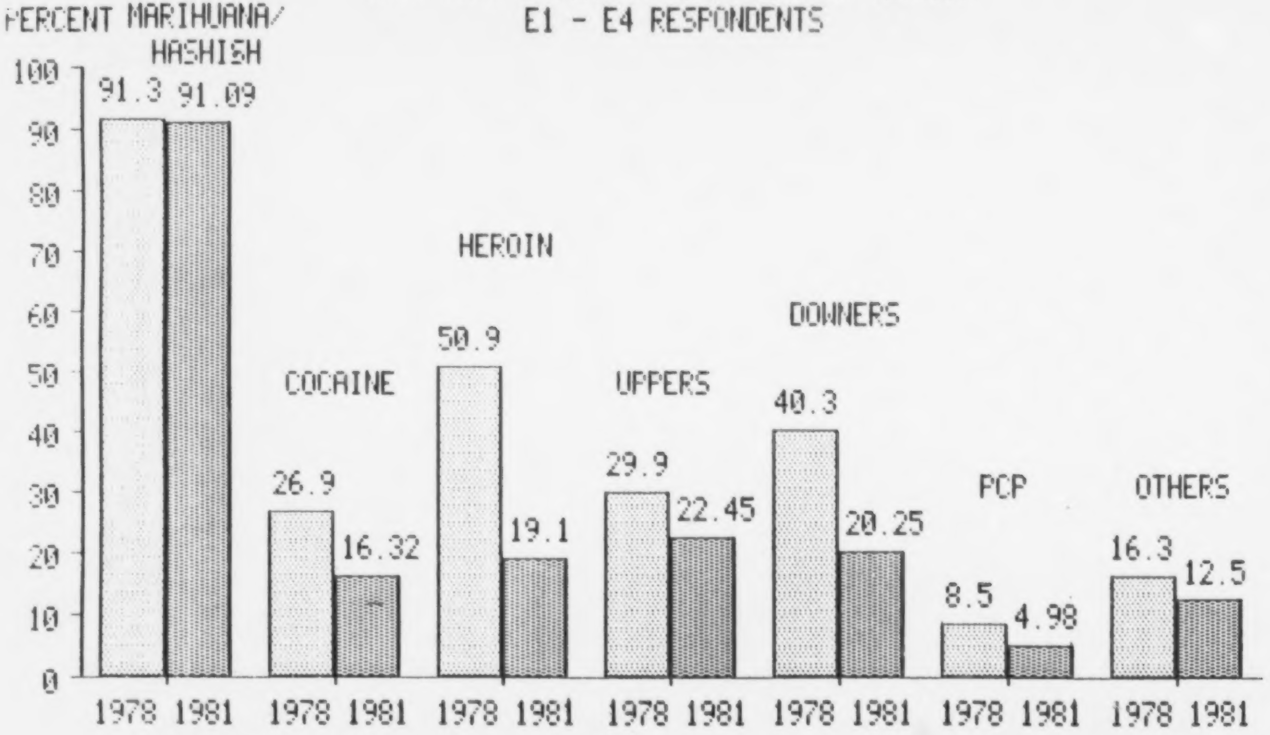
SOURCE: SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981)



QUESTION: WHICH OF THE FOLLOWING DRUGS ARE EASY TO GET IN THIS AREA?
U.S. ARMY - FEDERAL REPUBLIC OF GERMANY
E5 & ABOVE RESPONDENTS (1981)

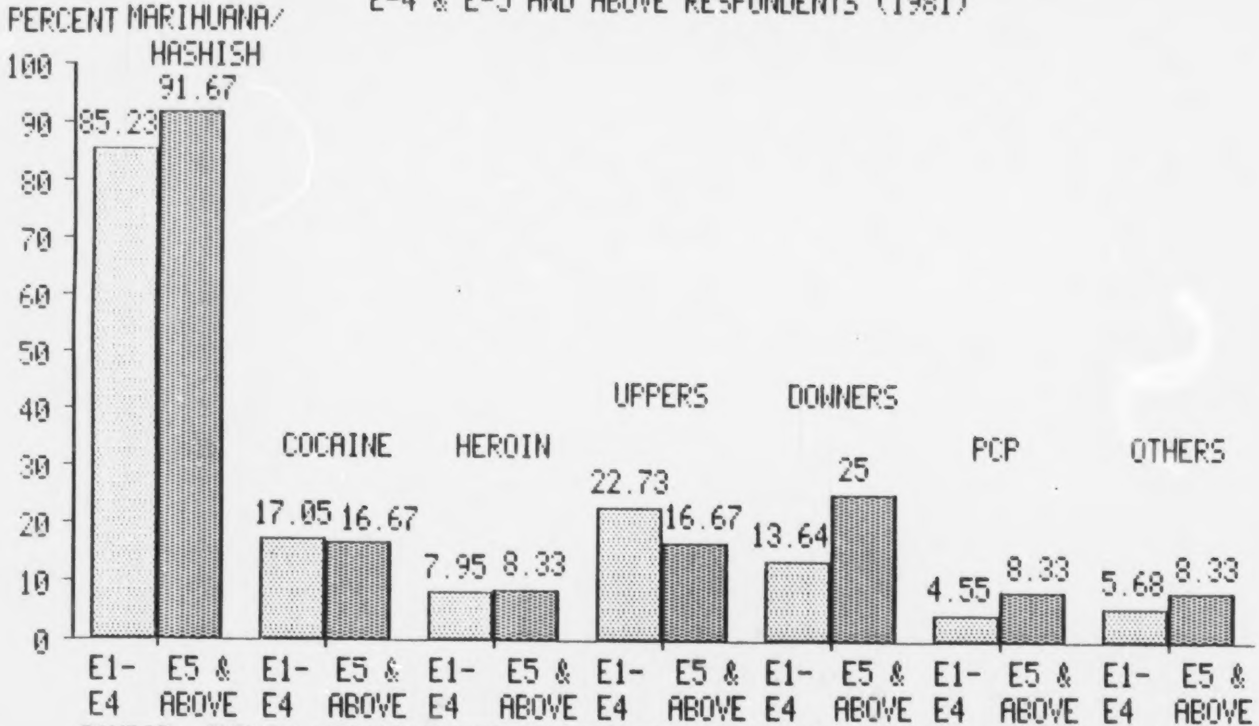
SOURCE: SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981).

QUESTION: WHICH OF THE FOLLOWING DRUGS ARE EASY TO GET IN THIS AREA?
U.S. ARMY - FEDERAL REPUBLIC OF GERMANY
E1 - E4 RESPONDENTS



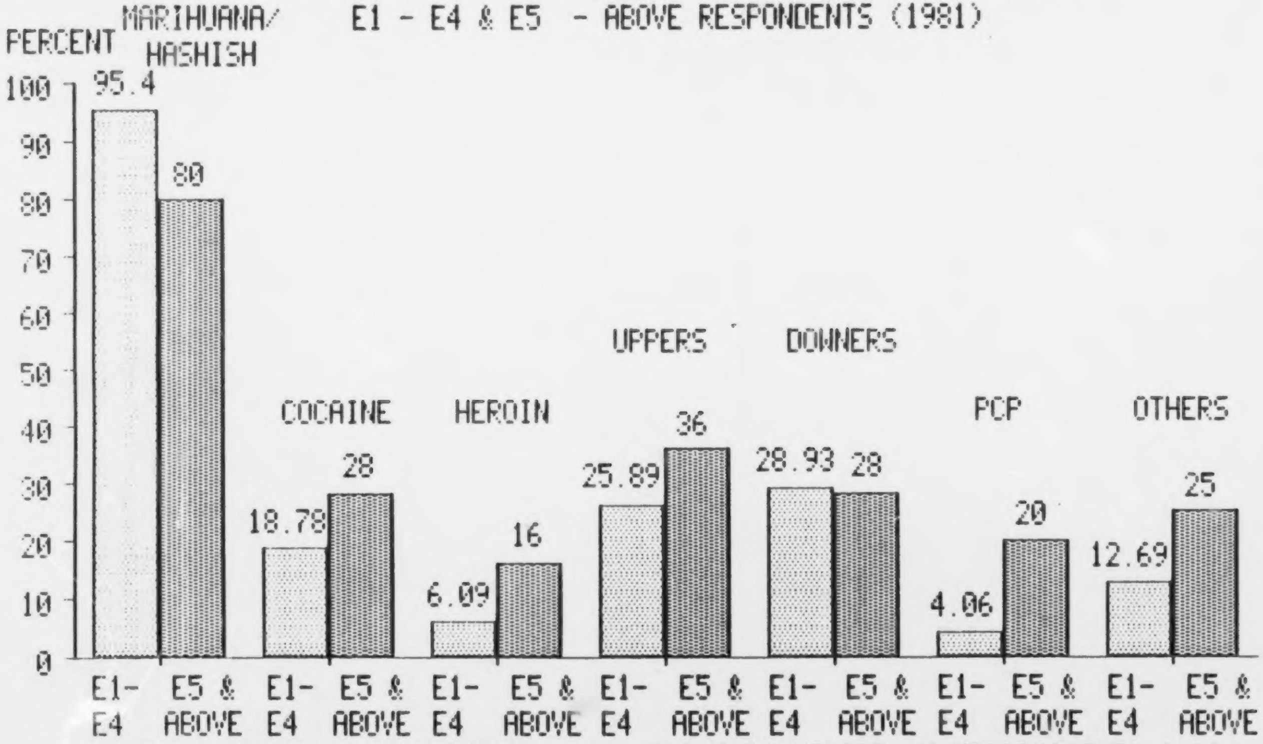
SOURCE: SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981)

QUESTION: WHICH OF THE FOLLOWING DRUGS ARE EASY TO GET IN THIS AREA?
U.S. AIR FORCE (RAMSTEIN AB, FED. REPUBLIC OF GERMANY)
E-4 & E-5 AND ABOVE RESPONDENTS (1981)



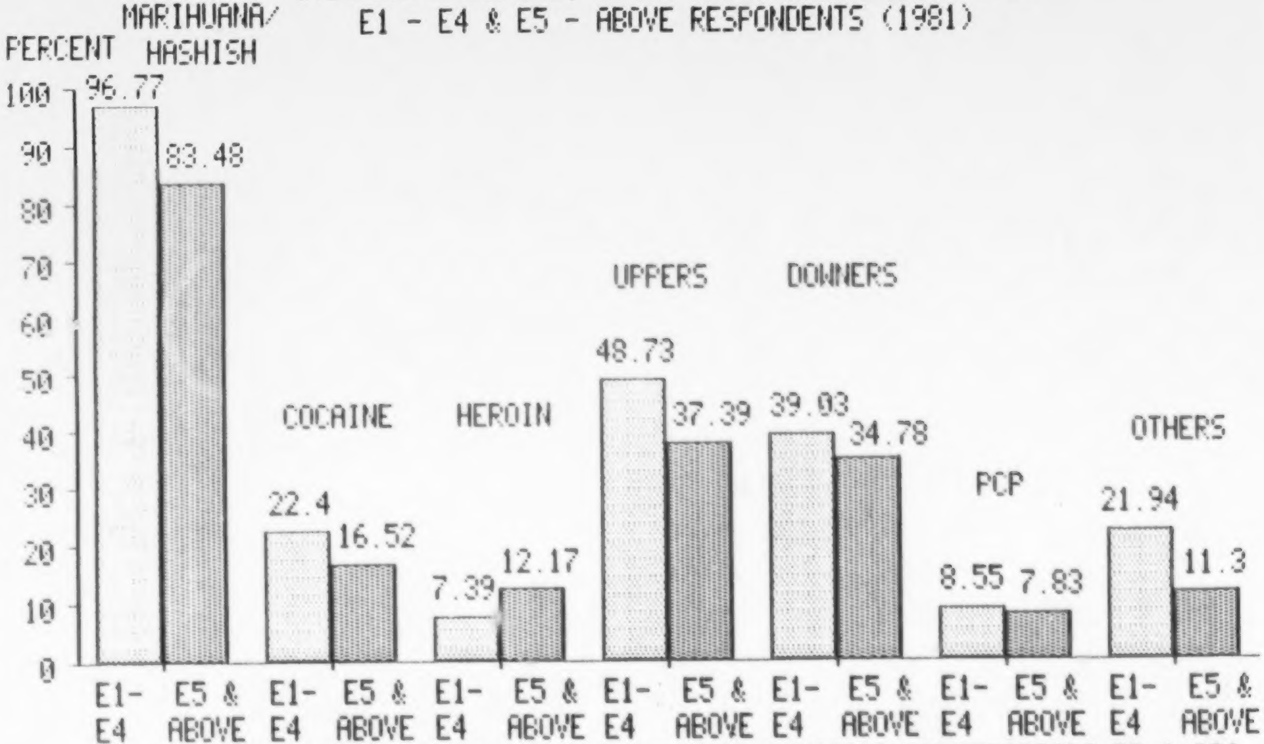
SOURCE: SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981)

QUESTION: WHICH OF THE FOLLOWING DRUGS ARE EASY TO GET IN THIS AREA?
U.S. MARINE CORPS (NAPLES, ITALY & 3 MED FLEET SHIPS)
E1 - E4 & E5 - ABOVE RESPONDENTS (1981)



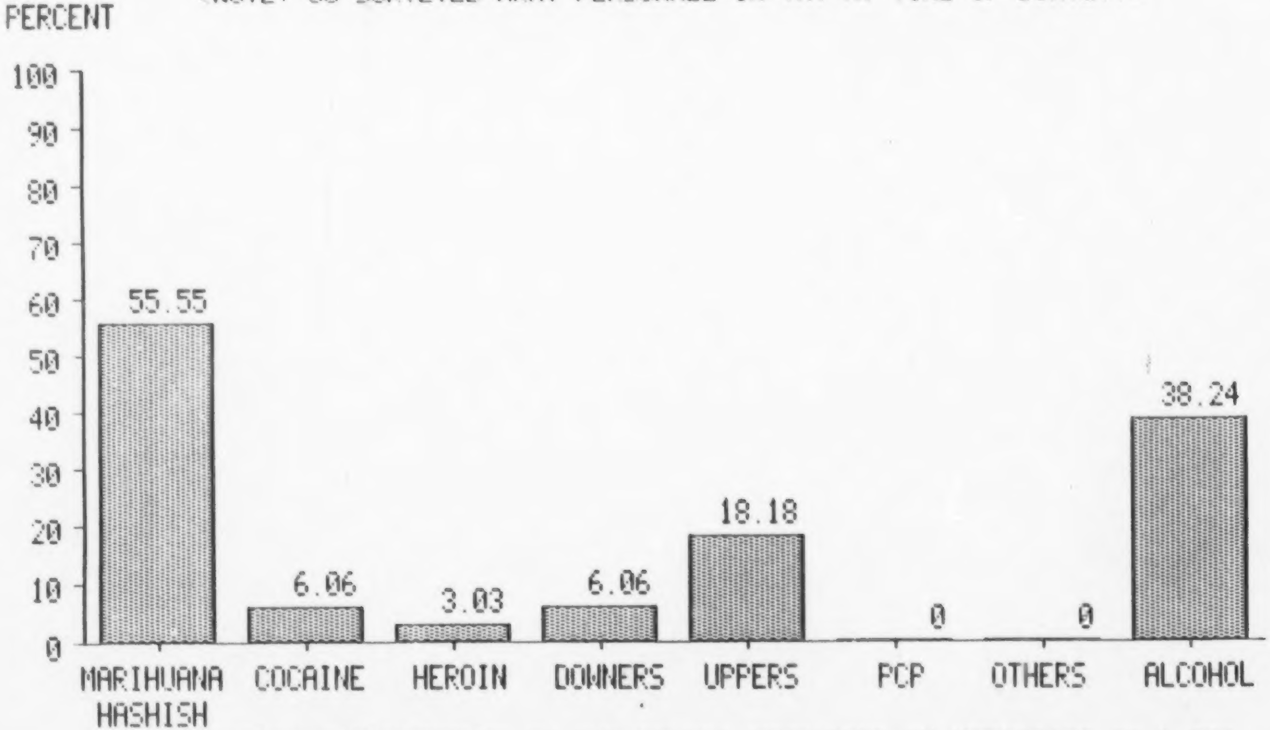
SOURCE SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981)

QUESTION: WHICH OF THE FOLLOWING DRUGS ARE EASY TO GET IN THIS AREA?
U.S. NAVY (NAPLES, ITALY AND 2 MED FLEET SHIPS)
E1 - E4 & E5 - ABOVE RESPONDENTS (1981)



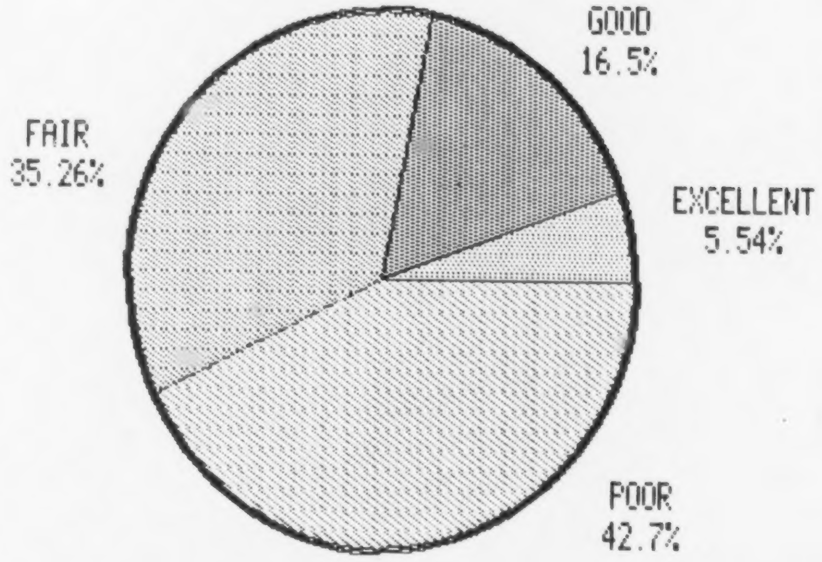
SOURCE: SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981)

USE OF DRUGS AND ALCOHOL ON DUTY (DURING WORKING HOURS) BY RESPONDENTS IN ARMY DRUG ALCOHOL TREATMENT PROGRAM AT TIME OF SURVEY
(NOTE: 38 SURVEYED ARMY PERSONNEL IN TMT AT TIME OF SURVEY.)



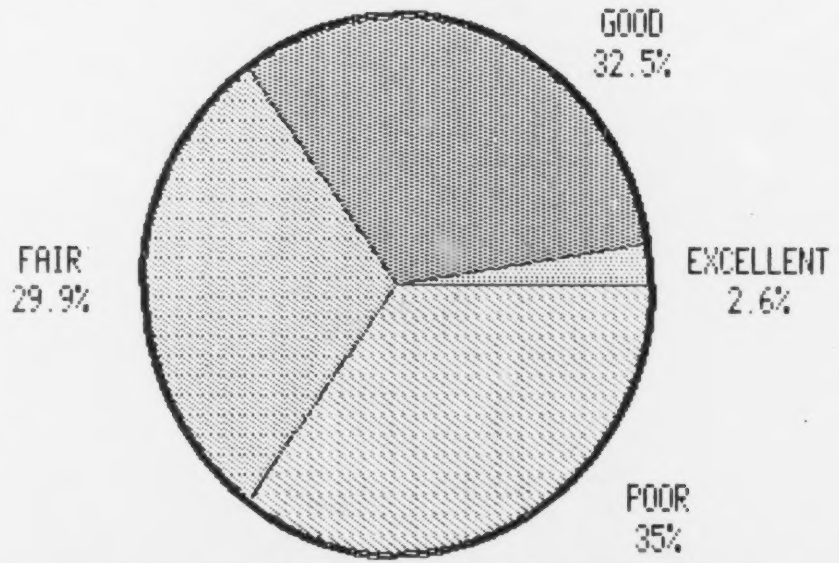
SOURCE: SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981)

EVALUATION OF ARMY'S DRUG ABUSE TREATMENT PROGRAM
BASED UPON A RESPONSE RATE OF 76.64%



SOURCE: SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981).

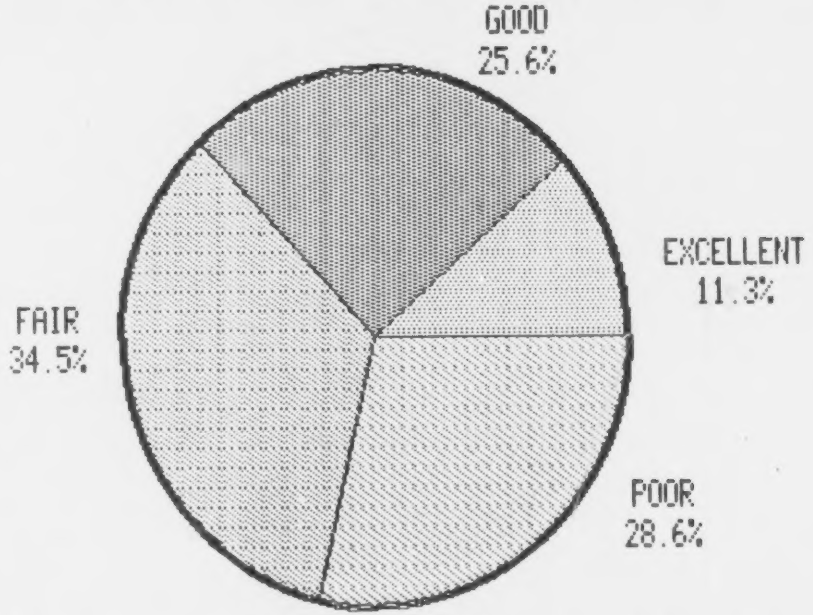
EVALUATION OF AIR FORCE DRUG ABUSE TREATMENT PROGRAM BASED UPON A RESPONSE RATE OF 77%



(AIR FORCE SURVEY CONDUCTED AT RAMSTEIN AB, FRG.)

SOURCE: SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981).

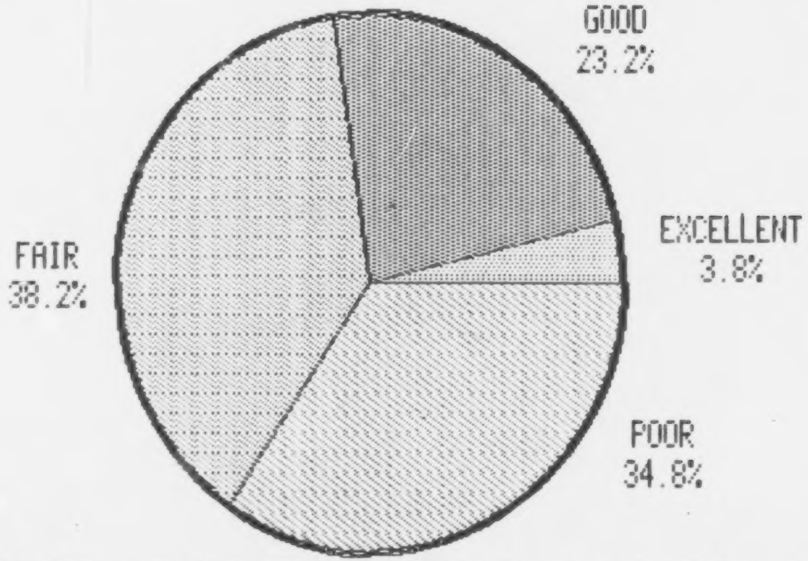
EVALUATION OF U.S. MARINE CORPS DRUG ABUSE TREATMENT PROGRAM
BASED UPON A RESPONSE RATE OF 75.68%



MARINES SURVEYED AT VARIOUS SHIPS & SHORE FACILITIES AT NAPLES, ITALY.

SOURCE: SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981).

EVALUATION OF U.S. NAVY DRUG ABUSE TREATMENT PROGRAM
BASED UPON A RESPONSE RATE OF 82.66%



(U.S. NAVAL PERSONNEL SURVEY ABOARD VARIOUS SHIPS & AT SHORE FACILITIES AT NAPLES, ITALY.)

SOURCE: SURVEY ADMINISTERED BY THE SELECT COMMITTEE ON NARCOTICS TO 1,906 U.S. MILITARY PERSONNEL IN ITALY AND THE FEDERAL REPUBLIC OF GERMANY (JUNE - JULY, 1981)